

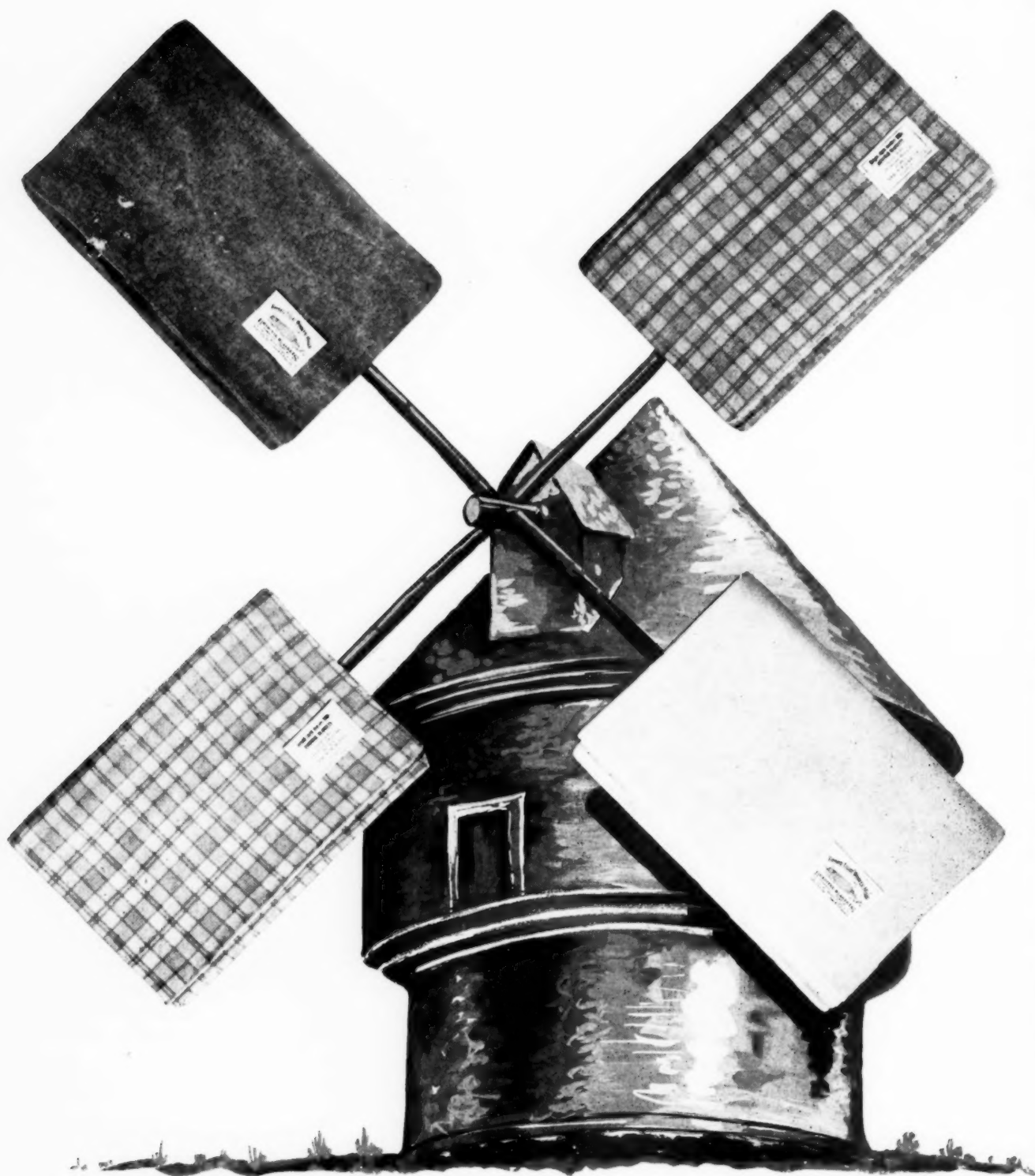


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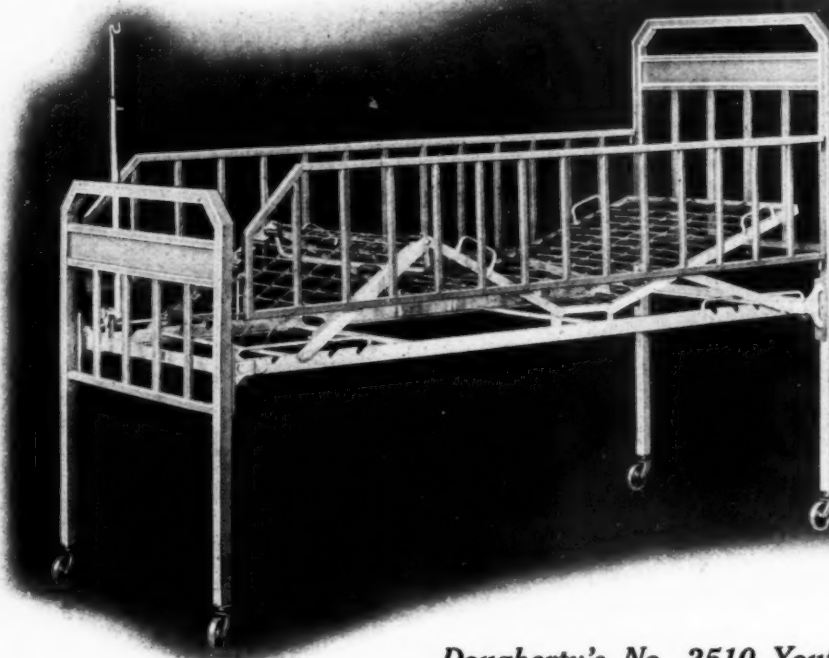
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXXI

October, 1928

No. 4

How to Evaluate a Hospital Site

A Paper from the American Hospital Association Meeting

By WILL G. CORLETT, A.I.A.

Reed & Corlett, Architects, Oakland, Calif.

RECOGNIZING the fact that hospital sites are often selected far ahead of consultation with an architect or hospital expert, that a going concern might already have its site when contemplating new construction or additions, or that the acceptance of a gift site influences the choice apparently beyond all other considerations, I believe it the duty of the hospital consultant or architect to make an issue of it.

It may be that a site previously selected can be sold to ultimate advantage in the purchase of another; a thorough investigation of future development may show a going concern better off to sell or abandon its site and begin over, or it may be that so much will be sacrificed in cost of construction or operating efficiency that a gift site had better not be accepted. The subject surely deserves serious consideration.

It goes without saying that when the opportunity of choosing

from two or more locations or properties arises careful unbiased investigation should be made.

With no claims for originality, I shall attempt to suggest a method of procedure that has been used and that has inherent merit and possibilities of development with more frequent use. The

idea can be adapted to all conditions or restrictions of program, can have the participation of any number of interested parties from one person to a considerable group of individuals, and is applied simultaneously to a group of possible sites.

It is obvious that the selection or approval of a site should be based on cold facts without bias. Sentiment, fancied economy, private or personal interest, prejudices, mere expediency, generalities, all tend to warp judgment. The method should overcome these difficulties and lay such reasons open for analysis.

The method of procedure I propose is

Common Errors

THE common use of obviously improper and unsuitable sites for hospitals should give cause for thought as to the reason therefor, the remedies or preventive measures that will obviate such blunders and the proper method of procedure to be followed by those who are responsible for the selection of a site.

Hospital sites can readily be found that were chosen for varying reasons. One location was chosen because the purchase price was cheap; another because it was donated; another because some influential agent wished to dispose of a particular piece of property; another because it was in the vicinity of a medical college; another because some staff member desired the hospital to be convenient to his residence or office. Too rarely was the site chosen because it was especially suited for a hospital building.

based on the assumption that in the case of any project or problem certain fundamental criteria can be set up as ideals, to be realized as nearly as practical considerations and provisions will permit.

Since it is rarely possible to obtain these ideal criteria, even in one separate fundamental phase, all practical and actual conditions of a site are only relative, perhaps never reaching the ideal, but in the case of various sites these phases vary in their relative desirability one with the other and in their approach to the ideal.

Let me assume that it is important to a community and to a group of backers contemplating the erection of a hospital that the institution shall supply hospital care of the best quality to the greatest number of patients at the smallest possible expense as regards (a) the construction of the hospital; (b) the maintenance of the hospital; (c) the expansion of the institution as the demand for hospital beds increases in the community and the success of the institution justifies it.

A list of important and fundamental considerations will be enumerated and explained and the relative ideal defined under each enumeration.

With the relative ideal defined it is possible to attempt a percentage rating of each site for each of the enumerated considerations, thus comparing any one site to any other in any particular, or in a summation of all considerations.

Ordinary judgment will dictate that the failure of a site to fulfill some primary requirement, such as size, should eliminate it even though it could be carried through the analysis to a high total rating.

Twelve Qualifying Characteristics

To present an example to illustrate the method and suggest a procedure, I have adopted twelve headings to define the ideal for comparison of available sites. Stated in their simplest way and explained later they are: (1) size; (2) expansion; (3) frontages; (4) orientation; (5) accessibility; (6) topography; (7) expense; (8) nuisances; (9) climate; (10) fire risk; (11) facilities; (12) cost.

Size: In this example it is assumed that the hospital must be maintained within the limits of a large city, close to the city's activities and must be built on a restricted area. The site nevertheless should be of sufficient size to insure privacy, and the general form and linear dimensions should be adaptable for building with a proper distribution of the area available.

The ideal size under these conditions can then be set up, say 300 by 400 feet.

Expansion: The ideal site would permit expansion

in a horizontal direction so that money will not be tied up in present construction for future development. It should be noted that vertical expansion may still be best but the ideal permits both vertical and horizontal expansion.

Notwithstanding that the founders of a hospital may believe that the institution they propose to build will serve the community and fill all of the requirements that the science of medicine may require for many years, it is obvious that it would be unwise to build without some study of the ultimate possibilities of the entire site or of land that may seem reasonably possible to acquire in the future, adjacent to the site.

Plan for Years Ahead

In the planning of a hospital, even if the amount of money available is insufficient to build immediately the hospital that the community needs, or that it is policy to build, an ideal program may be formulated in the hope that it will be realized step by step.

Frontages: The ideal site would have: (a) frontages on three or four sides with streets at least 80 feet wide; (b) facilities for parking automobiles of doctors and others in side streets, in such manner as not to be objectionable to the public; (c) protection from encroachment on all frontages by tall buildings or a general trend of commercial or industrial development in that district.

Orientation: The ideal is to have a site where all patients enjoy the maximum amount of sunshine. This can be accomplished by having a southerly exposure.

The ideal site would permit the planning and placing of the buildings to obtain the desired exposure, and would have the least desirable exposure where other conditions might force service entrances.

Accessibility: The ideal site should be easily reached, lessening the danger to very ill patients or emergency cases. It should also be accessible to friends and relatives of the patients for prompt and easy visiting.

Physicians must reach the site with a minimum expenditure of time, and supply service must be direct and prompt.

It should be susceptible of approach from all directions by means of wide thoroughfares for automobiles and within easy walking distances from main street car and bus lines.

Topography: The ideal site has a pleasant prospect from the patients' rooms without objectionable features in the foreground. An elevation, if the ground is rolling or hilly, is more desirable than lower ground and has the further advantage of good natural drainage. Freedom from drain-

age from adjoining property is most important.

Buildings upon an elevation will be constantly exposed to a more rapid current of air than they would be were they situated at a low point, especially if the low point is surrounded by other high buildings, and an airy situation is highly beneficial.

A level and adequate building platform with slight elevation above the streets, with main and service entrances reached by easy grades, is ideal and the location and surroundings should approach those desirable for a high-class residence.

A site with desirable trees, shrubs, plants and lawns that can be preserved has advantages.

Expense: The ideal site would require: (a) no grading or terracing; (b) no unusual foundation expense; (c) no unusual expense for drainage; (d) no unusual difficulties or expense for handling materials and construction equipment during construction; (e) no retaining walls and fences; (f) no destruction of existing landscape or other assets of the property.

The expenses dealt with here are expenses outside of the purchase price. The site should be rated highest for the minimum of these expenses. Expense caused by any or all of these items should be considered as part of the cost of the site.

Nuisances: The ideal site would be in a quiet portion of the city away from noisy railroads, street cars, heavy vehicular traffic, noisy factories, smoke, the dust of the streets, and neighboring buildings. There should be no objectionable odors, especially sewer gas or odors from seepage.

Freedom from dust is best accomplished by (a) selecting a knoll in a hilly city; (b) setting the building back from the streets a considerable distance with trees and shrubs along the edges of the grounds, which act as natural filters; or (c) by erecting a high building.

Environment Influences Recovery

Environment has much to do with the fundamental purpose of the institution—the improvement of the patient. The surrounding country, the aspect, remoteness from disturbing influences, and general charm of the site are all contributory elements for the process of recovery.

The sites should be rated in proportion as they are free from nuisances and have the desirable attributes mentioned.

Climate: Climatic conditions would be ideal in a warm, equable belt, not exposed to cold winds or north winds, storms or fog, and open to a maximum of sunlight throughout the year.

Fire Risk: The ideal site would have: (a) a minimum of exposure to buildings in the neigh-

borhood; (b) adequate fire protection; (c) accessibility for fire apparatus; (d) a low rate of insurance; (e) ease of removing patients.

Even in a perfectly fireproof hospital, with no actual danger of direct contact with fire, the risk of a panic is of sufficient importance to demand special attention to this feature in locating hospitals.

Facilities: The ideal site would have sewer, water, gas, electricity, and other services of adequate size convenient to hand. Sewers should be adequate to carry storm water.

Cost: The actual purchase price seems very important but the difference between costs of various sites is often offset by other previous considerations. There is danger in giving actual cost too much value. Cost per square foot, per frontage foot, future probable increment and present and probable future building restrictions are involved in this consideration.

The cost can be included in the analysis with the ideal cost being nothing.

Percentage Rating Given Each Site

With the enumeration and definition of these headings the next step is a simple tabulation of the sites, followed by twelve columns labeled with the assumed headings. Each site is then considered by the parties involved for one heading at a time, and a percentage rating given each site as the result of the discussion. With the completion of the tabulation an average of the twelve headings is taken for a general summation of percentage rating of each site.

An objection might be raised that this method gives equal value to each of the twelve headings. It is admitted that this criticism is well taken and that a possible weakness of the whole scheme is the impossibility of adopting headings that are equal in value. In practice this is not so serious as it appears for several reasons:

1. Assuming a total of nine or ten sites the first tabulation will definitely eliminate some sites, probably reducing the really desirable sites to about four.

2. With the elimination of all but four, some of the criteria headings can be eliminated as being satisfactory in all four sites, several headings can be combined in one, or additional headings may be made combining some of the previous headings.

3. It would then be possible to approximate the relative value of the various headings for any particular project, particularly after the elimination of some sites and some headings.

A supplementary analysis rating the four sites remaining should then be made, eliminating or

combining some of the previous headings as above described. It might be desirable at this time to add headings, such as composition and adaptability, combining some of the previous headings with these.

Composition may be used as a heading meaning the relation of the building to the form of the site, its aspect from adjoining streets and approaches, as well as such intangible qualities as charm, interest, general impressiveness and effectiveness.

Adaptability means the quality of the site that permits the fitting of a good type of plan to the given situation as regards outlook, approach, accessibility and service, and proper and full use of the area available under each site.

At this stage a preliminary study of possible types of block plans for each of the four sites is feasible, adopting the type which seems the most desirable for each of the four sites, and deciding which site will take the best type of plan.

It is not unusual to find that the relative position of the first four from the first analysis will change position in the supplementary analysis. When this happens the reason is apparent and is the result of closer analysis or the increased importance placed on some item or items.

Method Has Many Advantages

The advantages of an analysis of this sort might be summed up as follows:

The division of desirable qualities in a site into a number of subheadings, as described, permits concentration of discussion and argument on a definite basis. If a site seems to rate well under a certain heading the next one may be even better or the next one not quite so good, until there is close agreement among the interested parties as to the relative ratings of all sites. This division of discussion makes it difficult for prejudices to prevail and unfair, selfish interests are readily combatted.

Sentimental preference for any one site is automatically overcome by the proponent himself or the force of majority judgment. The results sometimes seem contrary to the first generalized judgment, but an analysis of the relative values in the table generally confirms the result of the tabulation. In the face of the tabulation it is difficult for an objector to find a weakness in the comparisons and he can be overruled. If the objection is legitimate it is easy to analyze and the ratings can be adjusted accordingly.

A definite record is also kept by this method and this is a protection for conscientious trustees or directors against haphazard criticism by critics without the true facts.

State Schools May Replenish Supply of Country Doctors

The rush of young doctors to practice in cities and urban centers is becoming a cause of much concern to rural leaders who see within the next few years their communities without adequate medical service. This concern is set forth in a letter sent to the American Medical Association by L. J. Taber, master of the National Grange and published in the *Illinois Medical Journal*.

The letter urges the association "to lend the weight of its influence to such readjustments and reforms in medical education as will serve to replenish the dwindling supply of country doctors and avert a general breakdown in rural medical service, which, unless present tendencies are arrested and corrected, appears to be inevitable."

Quoting statistics Mr. Taber points out that "since the average age at death of American physicians is sixty-two years, and since the average age of rural doctors throughout the country in 1925 was fifty-two years, the present generation of country doctors will have practically disappeared in another ten years."

"Careful inquiry," the letter continues, "reveals the fact that there are literally scores of rural counties in the United States where not a single doctor receiving his degree during the past ten years has settled. In the meantime we hear more and more of the increasing hosts in the rural sections who are medically helpless, while the cost of medical service, where it is to be had, mounts higher and higher.

"If the supply of country doctors is to be replenished these doctors must come from among the young men and women of the country districts as was the case in former times."

Emphasizing the need for more general practitioners Mr. Taber says: "It is the opinion of many physicians of highest standing that present medical education is not producing the most resourceful practitioners for ordinary service. It is giving practitioners who are dependent upon hospitals and laboratories, while these facilities according to authoritative medical opinions are necessary in hardly more than 10 per cent of illness and accidents. It is in the care of this 90 per cent of illness, for which independent, resourceful physicians are necessary, that the rural communities are mostly in need. This 90 per cent of illness cannot be handled through distant doctors and urban hospitals. If the people are to have adequate medical service, they must have physicians in their own communities."

The Community Must Determine the Policy

Unless the medical schools can offer some solution to the problem "it is for the people to determine whether it would not be a good policy, as necessity demands, for the states to build and maintain medical schools solely under public control and responsive to the needs of humanity," the letter suggests, and pledges the Grange "to follow wise medical leadership, to escape if possible the mistakes of unwise legislation which might open the doors to all sorts of incompetents."

"We are compelled by force of circumstances to be concerned with the usefulness of the medical graduates that are turned out and their apparent failure under present conditions to meet the needs of rural communities. . . . In our opinion the only adequate remedy will be found in the adoption of a more rational system of medical education," the letter concludes.



Industrial Service Solves This Hospital's Financial Problem

By C. W. FORDE, Jr.

Superintendent, Longview Memorial Hospital, Longview, Wash.

EARLY in the development of the city of Longview, Wash., it became evident that to keep pace with its progress and needs the community should have a hospital. This hospital must, of necessity, be in keeping with the other developments and capable of expansion to meet the growing city's requirements. After consideration of several plans, a meeting of citizens was called at which it was decided to make the hospital represent a community effort, not only of Longview but of the surrounding towns and country. Citizens' committees were organized and conducted a subscription campaign meeting with sufficient success to make possible a hospital of the first grade, with the floating of a bond issue. Six per cent stock certificates of twenty-five dollar denominations were sold. An architectural competition was conducted, and from the plans submitted for the proposed building the best in the opinion of competent judges was chosen. So came into being the Longview Memorial Hospital.

During the construction period a survey and study of hospital organization and equipment were conducted and the best points of each institution visited were incorporated in the new plant. On November 9, 1925, the hospital in America's newest city was opened for patients, so complete

in every detail that of it Dr. W. J. Mayo, Rochester, Minn., has said, "I have never seen a better equipped hospital than you have here. The arrangement is splendid and the laboratory is excellent. People of this community are to be congratulated that they have such an excellent place to send their sick."

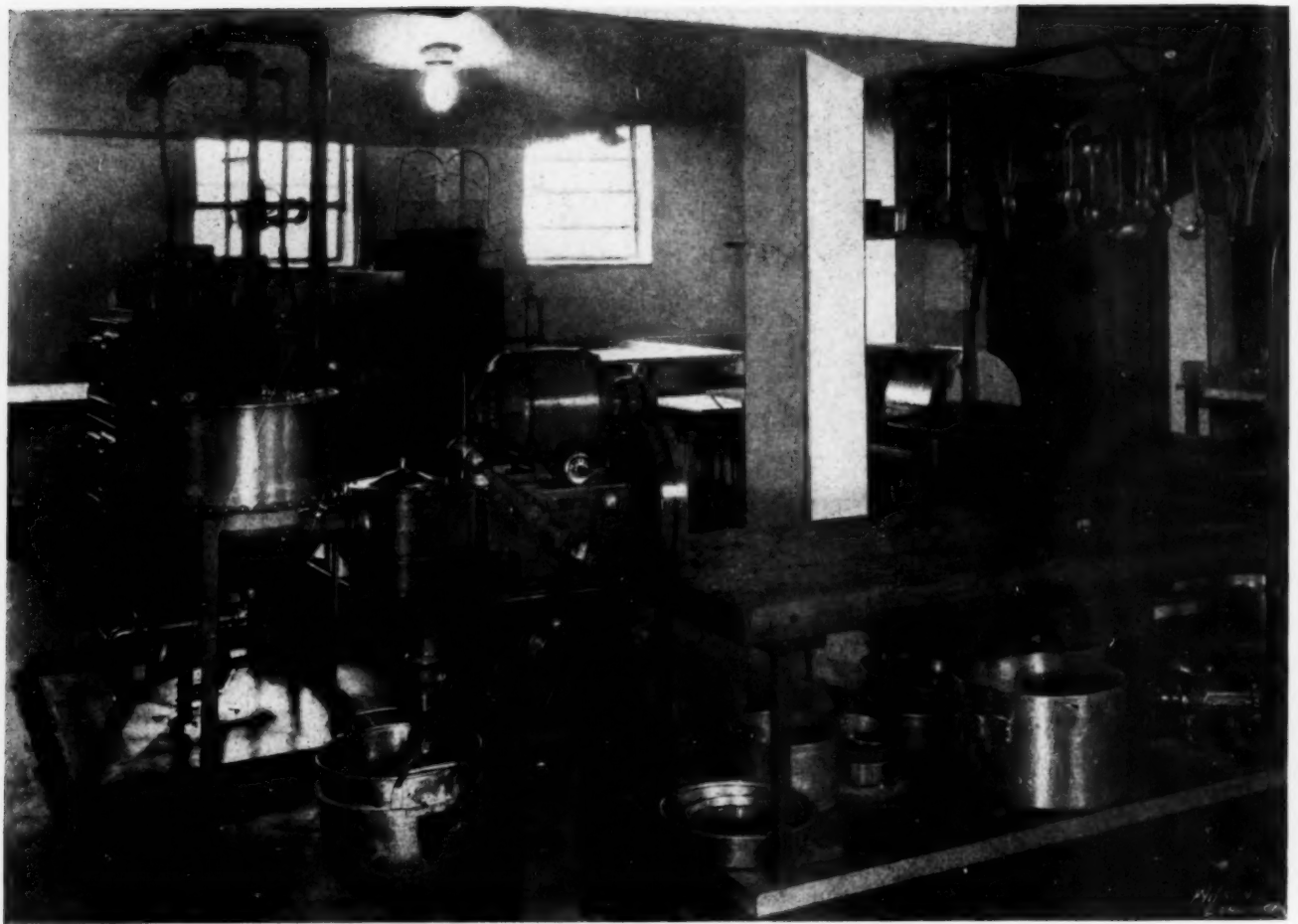
During the first year of its existence, the hospital was conditionally approved by the American College of Surgeons, and early in its second year it was recognized by the American Medical Association for a sixth year residency in specialties.

Site Carefully Chosen

The hospital's location was carefully chosen so as to make it readily accessible to the business, residential and industrial districts. It fronts on Lake Sacajawea Park, which circles the west side of town, and on Longview's sunken gardens.

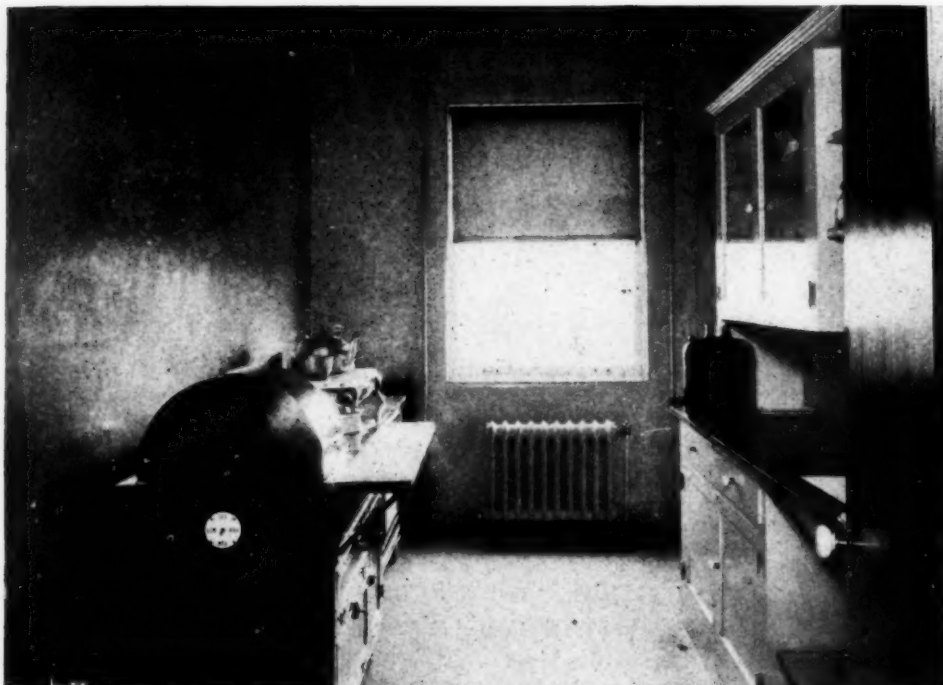
The building is four stories in height and is fire-resistive. It is of ninety-four bed capacity. Accommodations are provided for all classes of work usually found in a general hospital, except contagious cases.

On the ground floor are the emergency room, adjacent to the ambulance entrance; the cystoscopic room; the x-ray department, which is under the direction of a highly competent roent-



genologist and in which there is a full time technician; the autopsy room; the laboratory, in charge of a full time technician and supervised by one of the Northwest's leading pathologists,

who makes all tissue examinations and special reports; the central linen room; the nurses' dining room; the main kitchen, electrically equipped, and, in a separate wing, the power plant. Over



The upper picture shows the electrically equipped main kitchen from which all the food for the entire institution is distributed.

The diet kitchen is compactly arranged and of neat appearance. It represents the last word in modern diet kitchens.



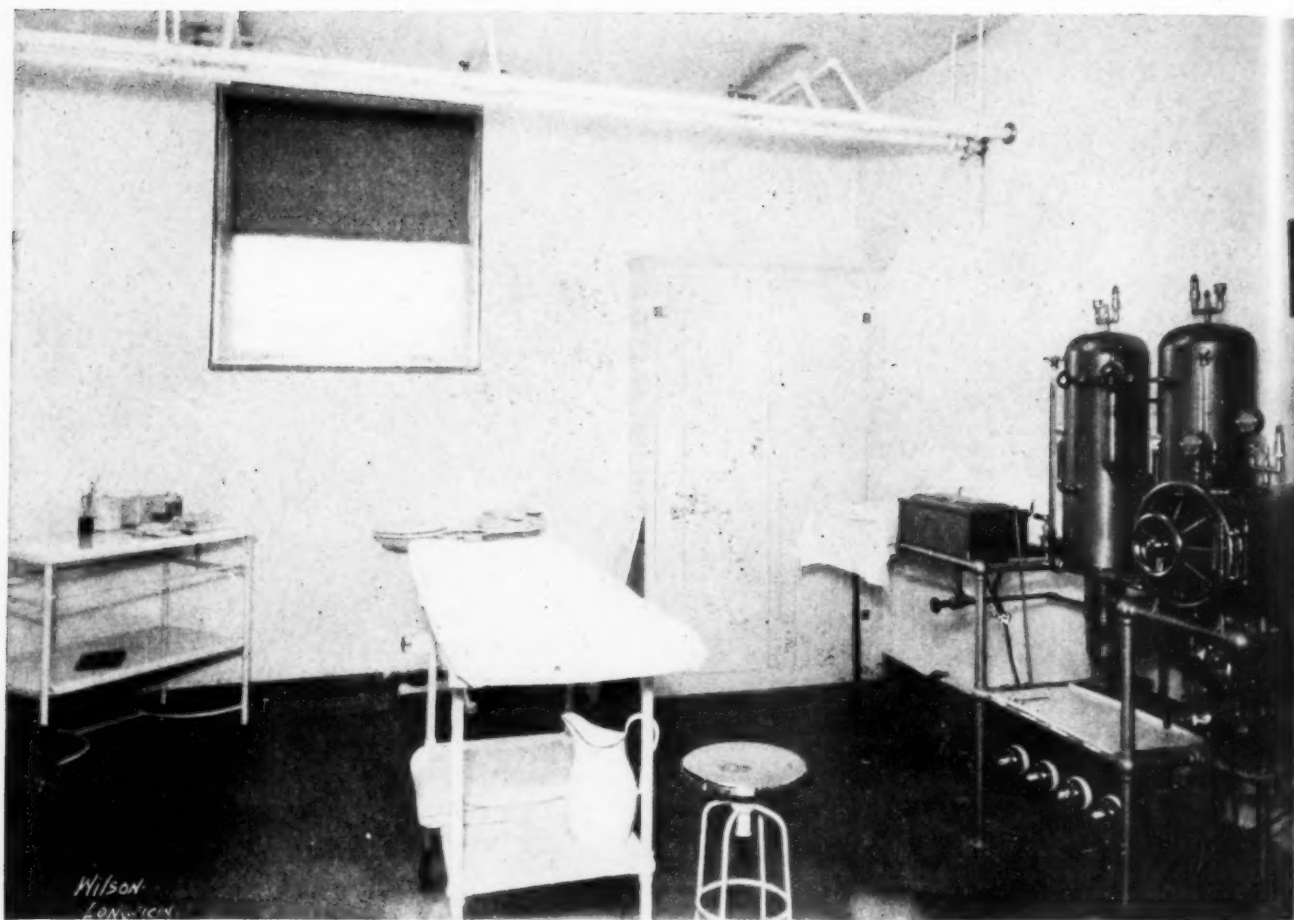
the power plant is provided space for the future installation of a laundry. The remaining three floors each have a dressing room, a utility room and a diet kitchen for preparing special diets.

Food is sent from the main kitchen to the floors in especially designed, electrically operated, rolling steam tables, which are capable of maintaining the temperature of the food for indefinite

The nursery in the upper picture is equipped with moveable cribs each of which contains four separate compartments.



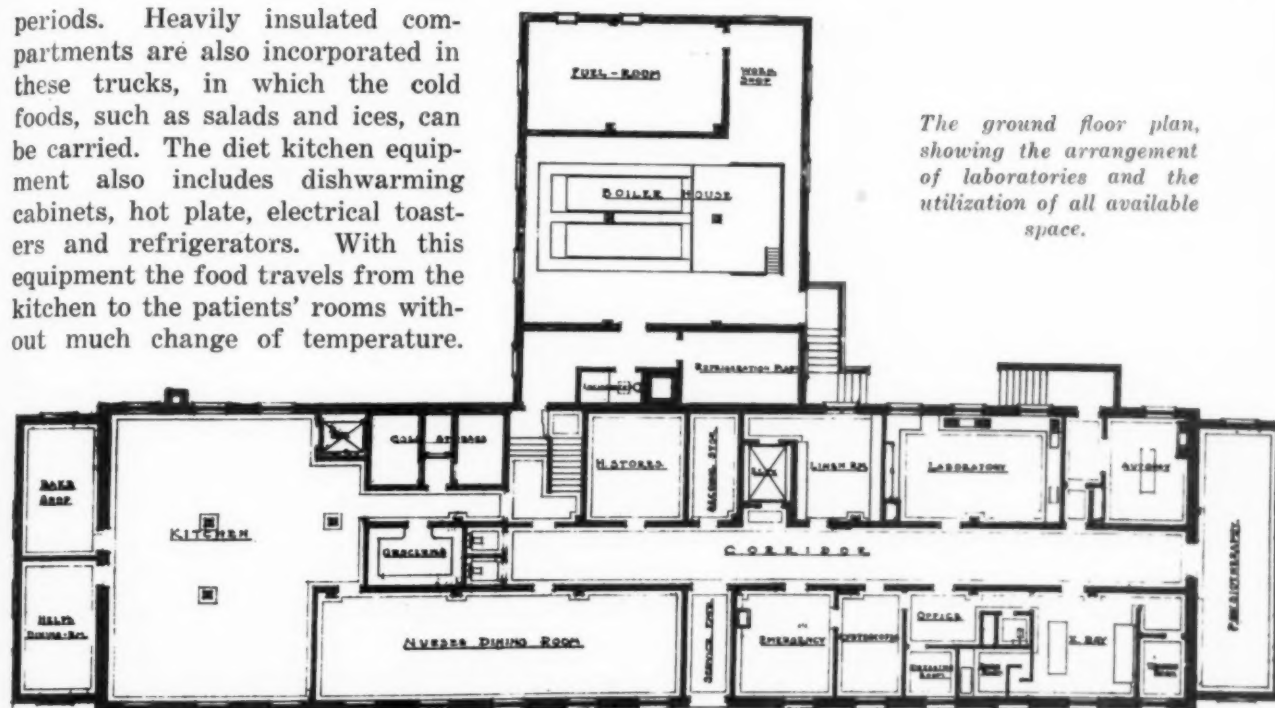
The lower picture shows a four-bed ward equipped with all steel furniture. This arrangement of beds is considered efficient.



The upper picture shows the emergency room which is often the scene of unexpected action. Everything is ready for immediate use.

The west end of the third floor is given over to obstetrical work. The lower picture shows the arrangement of equipment in the delivery room.

periods. Heavily insulated compartments are also incorporated in these trucks, in which the cold foods, such as salads and ices, can be carried. The diet kitchen equipment also includes dishwashing cabinets, hot plate, electrical toasters and refrigerators. With this equipment the food travels from the kitchen to the patients' rooms without much change of temperature.



The ground floor plan, showing the arrangement of laboratories and the utilization of all available space.

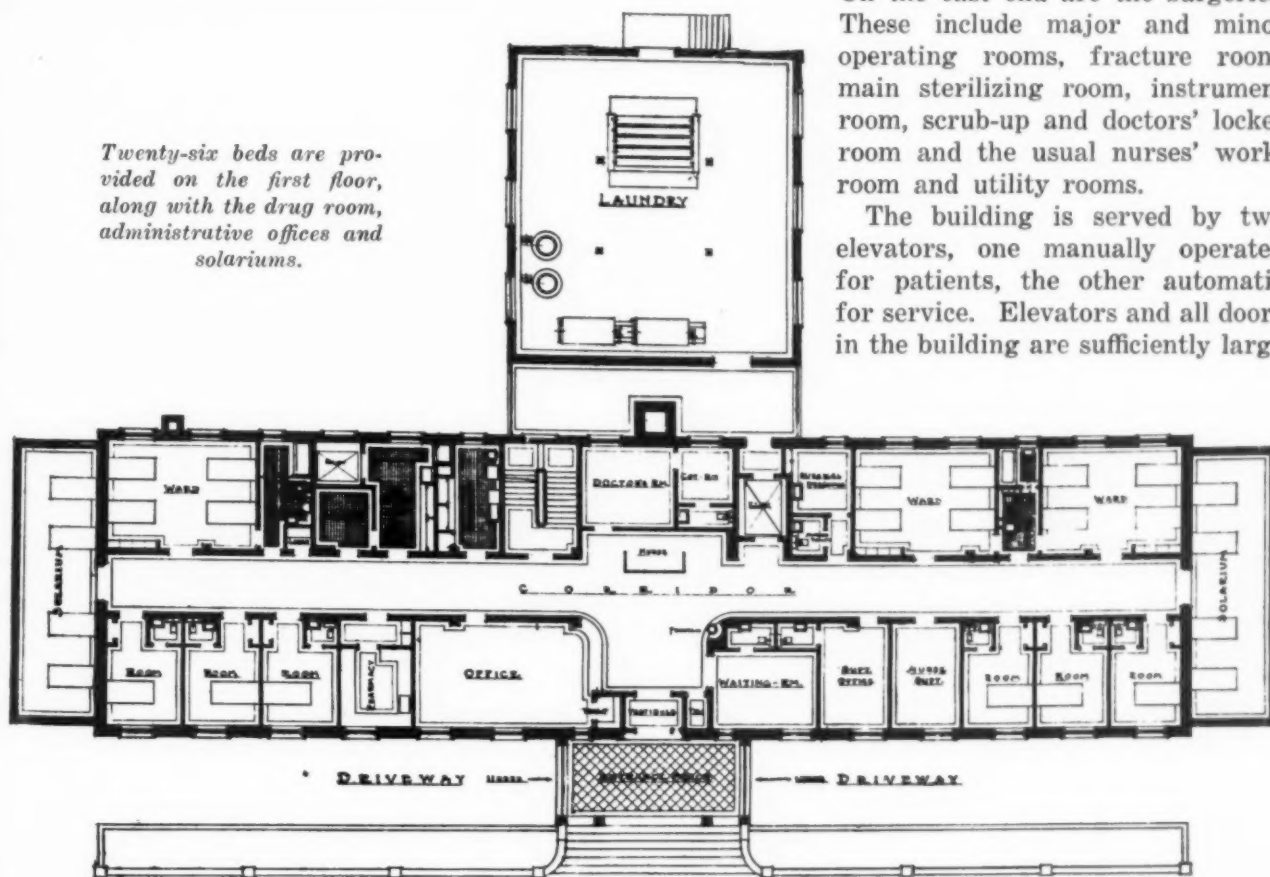
The first floor is devoted to the administrative offices, the drug room and the medical patients. Twenty-six beds are provided on this floor. The second floor is used for surgical and industrial patients, forty-two beds being available. On the

first and second floors, solariums are provided at the ends of the building. The west end of the third floor is given over to obstetrical work. Twenty-six beds are available, with labor room, delivery room, babies' dressing room and nursery.

On the east end are the surgeries. These include major and minor operating rooms, fracture room, main sterilizing room, instrument room, scrub-up and doctors' locker room and the usual nurses' work-room and utility rooms.

The building is served by two elevators, one manually operated for patients, the other automatic for service. Elevators and all doors in the building are sufficiently large

Twenty-six beds are provided on the first floor, along with the drug room, administrative offices and solariums.



that patients can be moved to any part of the building without being taken from their beds. Room accommodations range from private rooms, with adjoining baths, to four-bed wards. No ward accommodations larger than this are provided. Practically all rooms and wards have running water.

A resident physician is on duty at the hospital at all times. The nursing personnel is wholly composed of graduate, registered nurses. They are housed in a nurses' home immediately adjoining the hospital site.

Staff organization is on the open staff plan. These staff appointments include not only local doctors but those from adjoining towns. Local doctors compose the regular staff, those from outlying districts the visiting staff. The members of the visiting staff have the full privileges of the hospital, except that they are required to grant authority either to a member of the regular staff or to the resident doctor to act for them in emergencies.

How Industrial Service Functions

An interesting and unusual feature of our work is the plan adopted, through our industrial service, to guarantee the hospital sufficient income at all times to permit the work to be conducted on a high plane. Under the state compensation laws of the State of Washington, it is permissible for a doctor, individual or group to contract with the state and the industries to care for their industrial work in return for a certain fixed sum per man per working day, classified according to the hazardousness of the occupation of the employee. To create this insurance fund 50 per cent is collected from the employee and 50 per cent is paid by the employer. Eleven per cent of the fund so collected goes to the state, to create a sinking fund from which it pays time loss and disability claims, and 89 per cent goes to the party contracting to furnish the medical and hospital care.

In this case the Longview Memorial Hospital has contracted with all the major industries in its territory not only to perform this industrial service, but, further, has agreed, for the payment of an additional \$1.25 per month per employee, to furnish the employee with such medical, surgical, hospital and nursing care and medicines as may be necessary as the result of injuries that occur outside of the time of employment, and in all sickness except chronic conditions and a few like exceptions, in which case they are given free diagnosis, on condition that they report to the hospital and the doctors of our contract staff for treatment.

This contract staff is chosen from the regular

staff and its members act in the capacity of employees of the hospital, on salary. An employee who is sick or injured, obtains an order for medical attention, selects a doctor of the contract staff to care for him and receives all the attention of a private patient. This service may be received either at the doctor's office or at the hospital. Through this service an out-patient department registering upwards of one thousand calls per month is maintained.

First Aid Stations Maintained

In the larger industrial plants first aid stations in charge of graduate nurses are maintained. In one logging camp a graduate male nurse will be kept for first aid work. In Ryderwood, which is a logging center and a town of 2,500, a six-bed emergency hospital is maintained in charge of a full time doctor and nurse. A dentist is also on duty at this point. In addition to covering the employee himself, as is done in Longview, at Ryderwood a married man may pay \$2.40 per month and have his entire family protected by our health contract. At Ryderwood the patients present themselves to the emergency hospital for treatment. In case they need hospital care or the services of a specialist, they are given an order and transferred to Longview. In Ryderwood, as in Longview, chronic conditions, obstetrical cases and all conditions not common to both sexes are excluded from the contract privileges. Out-patient calls at this point number over eight thousand per year.

Ambulance service is maintained from this emergency hospital and from the industrial plants to the hospital at Longview.

Receipts from our contracts give us a fixed revenue, which is a great factor in helping to solve the financial problem of the hospital. About 40 per cent of all cases in the hospital are under our contract plan, the other 60 per cent being private, pay cases.

Thus has Longview solved its problem of the need of a hospital and been able to develop and maintain an institution whose equal is usually found only in the larger centers. With this revenue as a background, we are also able to face with confidence the problem of our future development in accordance with the needs of the community.

Longview has just celebrated its fifth anniversary. The past five years have seen its development from a valley of farms to a prosperous, thriving city of over 12,000 population, with all departments of a city government functioning. Its establishment has resulted in the establishment of another town which has already brought 25,000 new people into the surrounding country.

The Ability of Patients to Pay for Medical Care

A Paper from the American Hospital Association Meeting

THE report of the out-patient committee of the American Hospital Association presented at the meeting in San Francisco in August took up the two following questions: (1) What principles should be adopted as the basis for determining the patient's ability to pay for medical care? (2) What are the best methods or procedures whereby to carry out these principles in the everyday work of the clinic?

The committee quoted two paragraphs referring to the admission of patients in the standards of out-patient work adopted by the association in 1926, then continued with a description of the principles and methods in use in five clinics that have devoted special attention to this matter. These clinics are the out-patient department of Lakeside Hospital, Cleveland; the out-patient department of Michael Reese Hospital, Chicago; the Boston Dispensary, Boston; the Cornell Clinic, New York and the out-patient department of Harper Hospital, Detroit, Mich.

1. Out-patient department, Lakeside Hospital: Income and responsibilities:

In determining eligibility of patients, data on the income, size of family and responsibilities are secured from the applicant, and the margin

for medical care is computed after comparison of the income and expenditures of the patient or family with a standard budget.

The social worker secures this information in the initial interview with new patients and from old patients who require special services. The actual business relationship with the patient, however, is in the hands of the out-patient cashier rather than with the social worker. In this way the financial information is secured in its proper relationship to many other social factors, but the social worker does not stand in the eyes of the patient as the person who makes the final determination on a dollar-and-cents basis.

Budgets Based on Minimum Figures

The budgets used in determining eligibility are based on what are regarded as minimum figures throughout, using as a basis a suggestive budget for families of small income prepared by the home economics committee of the Associated Charities of Cleveland, and a study of rents on 100 application blanks of patients accepted for clinic care. The amounts allowed vary with the age of the children in the family, two sets of figures being given.

Certain variables are taken into consideration in determining the eligibility of each case:

*Abstract of the 1928 report of the committee on out-patient service of the American Hospital Association, John E. Ransom, Toledo, Ohio; Frank E. Wing, Boston; and Michael M. Davis, New York, chairman.

Budget as Utilized at Out-Patient Department of Lakeside Hospital
(Figures are on weekly basis. The budget is also calculated for larger families)

	M - W Single	M - W Young	M - W Young	1 Ch. Older	M - W Young	2 Ch. Older	M - W Young	3 Ch. Older
Food	\$7.00	\$5.00	\$6.70	\$8.30	\$7.90	\$10.85	\$9.45	\$13.40
Clothing and Toilet Articles	2.50	2.80	3.15	3.90	3.65	4.95	4.15	5.75
Rent	4.00	5.00	6.25	6.25	6.25	6.25	7.50	7.50
Car fare	1.00	1.12	1.12	1.12	1.12	1.12	1.12	1.25
Elect. ....	...	.20	.30	.30	.35	.35	.40	.40
Fuel .....	...	.90	.90	.90	.95	.95	1.00	1.00
Household supplies, Laundry and Cleaning .....	.75	.60	.60	.75	.80	.80	.90	.90
School supplies .....	...	...	...	.10	...	.20	...	.30
Adv., News, Ins., Recreation, Savs.	1.75	1.95	1.95	2.20	1.95	2.45	1.95	2.70
Total	17.00	17.57	21.12	23.82	22.97	27.92	26.47	33.20

1. The age of children, rent standards, educational standards, other dependents, debt, past illness, the degree of thrift and competence in managing the income are budget variables. These determine whether the larger or the small amount or a modification of either will be used in determining the patient's financial classification.

2. Certain diseases, due to their nature, will increase expenditures, such as diet, supplies, special clothing, special equipment, household supplies, and will also decrease income.

3. The expense of operating a home may necessarily be increased in an illness of the home manager, affecting the usual routine or plan of expenditures; she may be less able to do the laundry, cleaning, cooking and mending.

4. The cost of medical care is taken into consideration with the other variables.

Verification:

The names of all patients are cleared in the social service exchange. When there is any question as to the veracity of the statements or any evident incongruity, the patients' statements are verified through visits to the homes, interviews with employers, consultation of public records regarding property ownership or other natural sources of information.

2. Out-patient department of Michael Reese Hospital:

Admitting system:

Patients are interviewed continuously between 9 a. m. and 5 p. m., including the noon hour, for:

1. Admission: (a) new patients; (b) reinvestigation; (c) lost cards.

2. Change in rating classification.

3. Reduction or deferred payment of fees for admission, drugs and x-rays.

4. Ordering and payment plan for glasses, dental plates and appliances. (Note: Admitting department raises funds through interested organizations, groups or persons if patient is unable to pay on any appliance costing more than \$10.)

5. Children referred for admission to Michael Reese Hospital for tonsillectomies. (Note: Appointment is given, hospital fee determined and necessary follow-up and other clerical work in connection with this is handled in admitting department.)

Appointments Granted After Interview

Patients are seen in medical, pediatric and gynecological clinics by appointment only, and new patients for these clinics are interviewed before an appointment is made. As routine laboratory examinations, including urinalysis, blood and blood Wassermann are required of all patients admitted to these clinics, arrangements

are made for this to be completed before the patient's appointment.

A flat rate of fifty cents for laboratory work is made to all new patients. There are no subsequent fees for further laboratory examinations.

The daily average number of new patients interviewed for admission in April was twenty-one. Total daily average number of patients interviewed, 100. (On especially heavy days, as many as 175 patients are interviewed. This does not include patients who are seen for just a few moments for some minor request or are directed to someone else in the dispensary.)

How Economic Eligibility Is Estimated

We have two full time admitting workers. On especially heavy days, our stenographer, who is familiar with admitting work, assists in interviewing but makes no independent decisions.

The following information is obtained in estimating economic eligibility of patients applying for medical care:

Income and Responsibilities:

Income:

1. The father's occupation and industry, wages, regularity of employment.

2. The industry and occupation of all adult members of the family; what they earn and what they contribute.

3. Membership in a lodge or insurance company from which the applicant can obtain sick benefit.

4. Charity relief of any kind. (Sources?)

5. Other possible sources of income: property ownership, insurance return, home occupation, shop returns, boarders or roomers.

6. Savings.

Responsibilities:

1. The patient's expenditures.

2. The cost of maintaining the family when in its normal state.

Certain variable factors are considered in connection with the social and economic situation of the patient; such as (1) the individual who is ill and the source of reference. Is it the breadwinner, the woman of the household or a child? (2) the length of time of incapacity; (3) alternatives open to patients; (4) conditions of health of other members of the family.

The cost of medical care required is also considered in connection with the following items: (1) the type of illness; (2) the treatment necessary; (3) the type of medical care required and the approximate cost if obtained privately.

If the medical need is indefinite, the patient is admitted pending decision.

Use of Standard Budget for Comparison:

Income, responsibilities, etc., are compared with budgets estimated for a normal self-supporting family, a single self-supporting woman and a single self-supporting man.

Out-patient Department of Michael Reese Hospital, Minimum Financial Budget

These budgets are based on the minimum financial requirements of families in their respective groupings:

	2 Man and Woman	3 Man Woman Child, 3	4 Man Woman Girl, 5 Boy, 3	5 Man Woman Girl, 12 Girl, 5 Boy, 3
Food	\$ 29.10	\$ 34.40	\$ 40.16	\$ 48.58
Clothing ..	12.15	15.43	18.71	24.30
Rent	25.00	25.00	30.00	40.00
Household Furnish- ings	6.25	7.18	8.11	9.04
Fuel and Light ...	9.63	9.63	11.98	12.73
Extras	5.57	6.24	6.91	7.58
Total ...	\$ 87.70	\$ 97.88	\$ 115.87	\$ 142.23

Admission fees are graded, A, \$.50, B, \$.25, and C, free. Patients when interviewed are similarly classified as A, B, or C, according to their conformity to budget figures, and are required to pay the corresponding admitting fee. Drugs and x-rays are also divided into three classes, namely, A, B and C. Ineligibles are advised to consult a private physician, but in no case are they referred to any particular physician.

The conclusions as to costs on which these budgets are based were reached by a committee on social work, which supplied a staff to collect data on costs and amounts of material essential to families. These workers ascertained prices of food, clothing, fuel and household expenses in the different parts of Chicago, exclusive of expensive residential sections. They selected reliable families known to them who were maintaining a standard of living that corresponded to that adopted by the committee. The budget allowed a family the minimum of medical service and no provision for special needs.

Verification:

1. Sources of Information Other Than the Patient: (1) confidential exchange; (2) real estate index; (3) commercial agency (financial reports); (4) telephone directory; (5) contacts with relatives, lodges and employers.

2. General Sources of Information Available: (1) knowledge of salaries by types of employment; (2) industrial conditions at time of application (seasonal trades, union, nonunion, irregular work); (3) average rental by districts; (4)

knowledge of standards in the neighborhood.

3. Individual Investigation.

It was formerly the policy to set aside one half day each week for the admitting interviewer to make home calls and outside investigation. Recently this was discontinued on the basis of two assumptions: That such investigation is not necessary because few persons will submit themselves to clinic routine if their budget can possibly be made to cover the service of a private physician; and that if such outside investigation were necessary, the time assigned to it was entirely inadequate.

Home Investigation Often Needed

There are undoubtedly some cases where only by home investigation can a satisfactory decision be reached, but the staff is entirely inadequate to devote sufficient time to this. In cases where such doubt exists, the patient is assigned to the clinic and a special form is attached to the medical record informing the examining physician that a question as to the patient's eligibility has arisen, and his opinion is requested concerning the patient's complaint and the diagnostic services necessary. Any complaint received from members of the medical staff or outside physicians that patients have been admitted who could pay for private medical service is carefully followed up and a report of the investigation made to the physician.

3. Boston Dispensary:

In determining eligibility and rating, an income schedule is used as a guide to the admission officer. This schedule was worked out on the basis of the cost of living in Boston.

Income Scale for Admission to the Boston Dispensary

Single person getting meals in room.....	\$15.00
Single person getting meals out.....	18.00
Single person living with family.....	9.75
Couple	22.00
Couple with one child.....	25.50
Couple with two children.....	29.00
Couple with three children.....	32.50
Couple with four children.....	36.00
Couple with five children.....	39.50
Couple with six children.....	43.00
Couple with seven children.....	46.50
Add \$3.50 for each child.	

In addition to income and size of family the following facts are also inquired into and are considered: unemployment, length of illness, previous expense of patient, probable duration and cost of treatment for the disability for which relief is sought.

Patients who are found to have an income beyond the above schedule may be referred to the evening clinic or to private doctors. The admission fees in the morning clinics are 50 cents for adults, 25 cents for children, in the evening clinics, \$1.60 for first visit, \$1.00 for subsequent visits. The evening clinics are designed to meet the needs of people who are employed during the day and who are able to afford a moderate charge for medical services, but who are not able to go to a specialist in his private office. In general these are patients whose incomes are five to ten dollars above the scale used for morning patients.

4. Cornell Clinic:

This clinic was started in 1921 to serve those persons who were unable to pay at private office rates for the medical service that they needed, and whose financial status made them inappropriate patients for the ordinary clinics, which provide service free or at merely nominal costs. The fee is \$1.50 for each visit to a department, with special fees for laboratory tests, medicines and appliance, approximating costs. The clinic physicians are paid.

Three Principles Determine Eligibility

It was established at the beginning of the clinic that three principles were to guide in determining the eligibility of applicants:

1. Resources of the patient: This involves the income of the patient or family and the extent to which the patient can draw upon the family income for his personal medical needs.

2. Responsibilities: the size of the family; number of wage-earners; number of dependents; special obligations or responsibilities, such as to relatives or to creditors.

3. Usual cost, at private rates, of the kind of medical care required in the individual case.

Provision has been made at the admitting desk for careful registration of applicants, with inquiry into their means, in order to exclude patients who could easily afford to pay at the usual private rates. As Cornell has no free clinics, the admitting department has felt the responsibility of referring to other clinics applicants who are unable to meet the Cornell rates.

Use of Budget Schedule:

Patients in general considered eligible are single individuals with incomes from \$1,100 to \$1,800; families of two members with incomes from \$1,600 to \$2,200; of three members with incomes of \$1,850 to \$2,500; of four members with incomes of \$2,050 to \$2,750; of five members with incomes of \$2,200 to \$3,000. The range indicated is due to consideration of standards of living and other variable factors.

Any patient may be admitted for diagnosis at the written request of a physician, without financial investigation.

5. Out-patient department, Harper Hospital: Income and Responsibilities:

Information is secured concerning the type and probable duration of illness, the occupation, wages and length of employment of each member of the family, and income from roomers, boarders and children, savings, insurance and lodge. Ownership of automobile, rent, payments on home, and debts are considered.

Use of Budget:

The income and responsibilities are compared with a minimum family budget for a month, covering food, clothing, rent, furnishings, fuel and light, extras. This clinic has a system of admission fees in four grades, \$1, 50 cents, 25 cents and for no fee. Patients on admission are assigned to one of these grades or are deemed ineligible and referred to private care. As an aid in verifying statements, a blank is sent to employers for weekly information concerning wages.

The clinic executive, who is a social worker, also makes home investigations for the purpose of financial investigation.

Minimum Family Budget for Month

	2	3	4	5
	Man Woman	Man Woman Child, 3	Man Woman Girl, 5 Boy, 3	Man Woman Girl, 12 Girl, 5 Boy, 3
Food	\$26.70	\$32.55	\$ 38.85	\$ 45.13
Clothing	11.43	14.13	16.94	21.31
Rent	22.00	22.00	30.00	35.00
Furnishings ..	5.86	6.73	7.60	8.47
Fuel and Light	9.71	9.71	11.78	12.43
Extras	5.57	6.24	6.91	7.58
Total	\$81.27	\$91.36	\$112.08	\$129.92

The committee also included in its report a statement of principles affecting patients' ability to pay which was prepared during a recent survey of clinics in Cincinnati.

The committee concluded from its review of the methods described at these five representative clinics that certain fundamental policies and procedures are held in common—those of the standards of the American Hospital Association.

It also noted that each particular clinic would require adaptation of the principles in detail to meet its particular needs. It discussed the variations of budgets according to community and the necessity for frequent revision, stressed the fact that no budget can be applied rigidly and that numerous other factors besides family income must be taken into consideration.

How the Personnel Worker of a State Hospital Functions

By J. ALLEN JACKSON, M.D.

Superintendent, Danville State Hospital, Danville, Pa.

ENCOURAGED by the example of large corporations and businesses in establishing cordial and mutually helpful relations with their employees through the medium of the welfare worker, the superintendent of the Danville State Hospital, Danville, Pa., has made what is proving to be an exceedingly successful move by adding to his official family a new member—the personnel welfare worker.

The duties of the personnel welfare worker at the Danville State Hospital in no wise resemble those of the usual personnel officer. They are strictly social and have to do with seeing that the new employee is given a cordial welcome and is made happy in his new work.

The personnel welfare worker provides the right religious, social and diversional contact for the newcomer during his adaptation period; companionship and leadership for those groups classed as laundry workers and domestics, and starts in the right direction men and women who are not under the supervision of the directress of the training school. She makes contacts with the employees' homes, wives and children, not in a paternalistic but in a purely social way. She is with them in times of illness or economic distress, to comfort and to serve. She is the counselor of the young mother with her first baby; she is the confidante of the newly married wife.

Need for Welfare Worker Apparent

That there is need for such an officer in hospital personnel groups can be readily shown. The average employee entering hospital service is thrown on his own resources so far as first contacts are concerned. Some of these are good, but except in a high type of person, usually they are bad. Domestic groups and laundry groups are "robots" so far as the hospital is concerned. Badly quartered, badly housed and free from supervision they, like the attendant of old, go from "pillar to post." Most important of all, little is known about them.

Then, too, there are the regular long-time employees. The man with the large family, the invalid wife or child; those experiencing sickness

or death in the family; the newly married couple; the mother, possibly a former hospital attachée, with her first baby.

It was through observation of such conditions among hospital employees that the superintendent of the Danville State Hospital, desirous of forming a happy medium of contact between the hospital supervising office and the individual employee and his family, was led to enlist the services of the personnel welfare worker. But first there had to be devised ways and means of inaugurating such a service, without involving the administrative office in the discussion of wages, time off, complaints about superior officers, departmental squabbles and other matters of a like nature.

Welfare Worker Is Also Librarian

It was found that by combining the job of librarian and welfare worker it was possible to fill two important niches. The recognized standards of wages, qualifications and hours off duty, made mandatory by the state rules and regulations, did away at once with this phase of possible complications. The fact that the members of the hospital personnel live in a small community and that the personnel officer provides her own automobile simplified the approach tremendously.

A person with years of experience in personnel welfare work was appointed, with full authority to proceed as librarian and welfare worker. Sufficient time has now elapsed to permit of conclusions regarding the value of the work, and the results are found to be gratifying. We feel warranted, therefore, in presenting the more detailed duties of the position and in giving case citations to show that efforts along this line in special groups were and are needed; and in describing the problems that confronted us, and the reactions to our efforts on the part of the employees.

In working with the general or entire group of employees, the welfare worker visits the homes, in each case making a friendly contact between the home and the institution. She makes special visits to the sick employees at home or in

the hospital. To those who are sick at home she takes flowers or a potted plant from the hospital greenhouse. In the case of death she is there to console and to help. At the same time she makes a study of home conditions and unobtrusively obtains a knowledge of the home life and environment, which is always helpful in dealing with the personality of the employee. She helps to create a home atmosphere by putting newcomers, other than members of the training school, in touch with friends in town and with the churches of their particular denomination.

In working with specific groups, such as those of the laundry and kitchen, she mothers the girls and makes plans for their wholesome social diversion. She shares their confidences, learns of their home conditions, and by tactful questions discovers the best means to approach and work with them. She discusses with them matters involving ethics and religion, nor is the question of personal hygiene neglected. She walks with them; plans treats and picnics in the woods for them, which form the basis of delightful nature study. Fascinating stories are read and told, and equally fascinating games are played.

The personnel welfare worker is able to do much good through simple, informal visits with the girls in their rooms. There she examines the wardrobes, so proudly displayed, and offers suggestions for adding to them or for remodeling some of the apparel. She assists those who are learning to make their own clothes; she plans with them about the best way to save money; she guides them in their choice of reading material; she looks after their physical defects, personally taking to the doctor or to the dentist the girl who, if left to herself, would not go.

Case Records Show Results

To cite a few of the actual cases on record will show how integral a part the personnel welfare worker plays in the life of the hospital community:

Case I. Family: father, mother, son, daughter, old aunt.

Employee: son, support of the family. Father ill; hospitalized in May; returned home and died in November. Mother ill in May and November. Visits made; counsel and aid given; flowers sent. Woman hired to care for the mother; son and daughter both working.

Case II. Family: father, mother, two sons, married daughter.

Employees: father and mother. Mother taken ill with bronchial pneumonia. Counsel and help given to daughter during mother's illness. Mother died. Flowers sent and funeral attended.

Case III. Family: father, mother, three months' old baby. Father an employee. Visits made and service given in line with the needs of a mother with her first baby.

Case IV. Family: father, mother, two babies. Father an employee. Father disabled. Family in distress. Difficult to get groceries, coal; landlord dunning them for the rent. Credit extended; shelter assured; material aid given.

Case V. Family: mother, father and several children. Father an employee. Child ill; difficult to procure medical services. Visits made, advice given and professional services procured; hospitalization recommended. Assistance given with child's wardrobe during hospitalized period.

Case citations dealing with individual problems of the laundry and domestic groups are of such a nature that they will be held inviolate. In a general way these reflect divorces, marriage incompatibilities, drinking and promiscuity, slovenly tendencies, and tendencies to dishonesty and lying.

Difficult Problems Encountered

On the whole the results, although gratifying in their relation to the employees in general, to family visits, to giving service where needed, cannot overshadow certain problems arising among the new employees of the domestic and laundry groups, problems to which, despite the great strides that have been made, the solution is not yet in sight. It is difficult, if a girl leaves school early, goes to work, tires of drudging and wants something better, to aid her in making up in some way for lost opportunities.

It is almost impossible to impress on these young women the thought that extravagant dressing is a luxury beyond their plane of living. Replacing low ideals with high ideals is a real problem. How can we, for instance, raise the slovenly to the tidy class? How can we protect the good girl from the evil influence of a domestic associate during working hours, recreation periods or in their quarters? How shall we divert the thoughts of the potential sex offender into more wholesome channels?

In the matter of special groups, while the results show many problems that will have to be worked out in the future, we are sufficiently impressed with the situation to know that in some way standards regarding wages and living conditions, warranting a higher qualification of the applicants, must be brought about. In the meantime, however, the hospital owes to itself and to the faithful people in those groups, the services of an experienced, well trained, personnel officer, who has duties and functions as outlined here.

Can a Hospital Raise Funds by Advertising?

CAN a hospital raise funds by advertising? Evanston Hospital, in the well known Chicago suburb, gives an affirmative answer to this question. It has proved that a modern hospital has plenty of "selling points," as an advertising man would say; and that even paid advertising brings results that any commercial firm might enjoy.

Each year Evanston Hospital conducts a Hos-

We Were Born in Evanston Hospital



WHEN STORK TIME COMES

The stork comes often to Evanston Hospital. To be exact, two or three times a day, 234 times in all during 1927.

He is a funny old bird, and looks on the floor accommodations; for his cargo is precious. Evanston Hospital gives him all that he craves.

Here, in happy yet anxious moments, Evanston mothers find a temporary home. Another EVANSTON home close to their real one.

Evanston fathers drop in, unconsciously, to peek through the nursery window—for they must not enter.

Unimaginative persons sometimes ask "Why a community hospital?" They forget Stork Time, for instance.

But fathers and mothers know. They appreciate the close-at-hand skill that is ready, waiting. No dreaded trip to a distant place, among total strangers.

Yet, such time is important in Evanston Hospital, every minute, every second—even back through the days and weeks of expectancy.

Still, it is only part of the day's work in Evanston Hospital. Evanston Hospital is serving ALL the people of the community ALL the time, sometimes directly, sometimes indirectly. Much of its work is for mothers, babies, and others, who cannot pay for what they receive. Therefore it relies on the generosity of citizens for aid.

Evanston COULD get along without Evanston Hospital. But it would not be quite the same city. Not quite so human, not quite so enlightened, and not so safe and desirable to live in—because not so prosperous.

February 12 is Hospital Sunday. If you do not place your donation through an Evanston church, send it direct to the Treasurer, Evanston Hospital.

This advertisement brings home to mothers and fathers that the community hospital is a valuable asset.

pital Sunday to meet deficits in the current budget. The citizens expect it. But the fate of Hospital Sunday is not left to the vague impulses of the moment. The community is prepared for it by a campaign of advertising covering the several weeks preceding the big event.

There is no asking for charity in the customary sense; no blushing apologies are offered. The work of the hospital and its worth to the community are presented. The rest is left to the enlightened self-interest, the humanitarian senti-

ments and the civic pride of the community.

Of course those who spend their lives in hospital work are sometimes least able to appreciate what the "selling points" of such an institution are. They know too much about hospitals, and hesitate to tell the public what seems so obvious to themselves.

The case is not so with Ada Belle McCleery, superintendent, Evanston Hospital, who has considered it as a part of her duties to develop a fine "publicity sense." And to assist her she calls in an advertising agency to develop the "outside slant" in advertising copy. This advertising agency counsel and service have always been contributed.

The assumption in each of these campaigns is that the people of Evanston, a great many of them at least, do not know the facts about Evanston Hospital. They must continually be reformed. For although Evanston is perhaps a city above

"Hard Luck"



Yes, but he had Invisible Friends

THIS little lad, brand as you see him in a HILKIN FRAME, had hard luck in double measure. A crushed leg is bad, but worse when you're without father, or money, or immediate friends.

In fact, your whole life's happiness and usefulness are at stake.

But he had INVISIBLE FRIENDS. A nurse told him that "the angels" would see that he got well all right. "Wine nurse!"

At any rate, Science did its work. Careful nursing and patience restored a limb. He will find it useful in life's battle.

Who is he? His name is "Legion." He is one of the host of helpless, luckless little children that American hospitals know. Evanston Hospital has its share. Their fathers and mothers, brothers and sisters, are the big-hearted public; we who they never see, and who never are their invisible friends.

Happily, not all are as bad off as this little fellow. But unless little legs, arms, noses, throats, eyes are attended to—unless little hearts and lungs are strengthened, many of these unfortunate ones will grow up handicapped—and some of them blind.

Earlier each year grow the methods of healing science. New inventions and discoveries require new apparatus, and large, technical requests. But who can measure the cost of such things against the life and happiness of even "one of the least of these?"

One third of the patients of Evanston Hospital pay their way. The rest—mostly little children—are dependent upon invisible friends.

Would you not like to join this glorious company?

You can, on Hospital Sunday.

Hospital Sunday is on February 12. If you are not affiliated with an Evanston Church, send your contribution direct to Evanston Hospital, care of the Treasurer.

Here the appeal is to the parental instinct. Such an advertisement brings prompt response.

the average in culture, a city of prosperous homes, churches, and institutions of learning, yet it has all the customary misunderstandings about hospitals. It cannot understand, for instance, that the saying "the poor you have with you always," applies to Evanston. Only current facts and hard reasoning can assure it that Evanston Hospital is no exception to the general rule, that there is much gratuitous work that the hospital must do, and that the interest of the community demands that it be done.

Of course the public thinks that Evanston Hospital rates are exorbitant. Here again there is a lot of ground to till. It must be explained that paying patients are not taxed for charity cases, and the varieties of service that each patient receives in a modernly equipped hospital must be enumerated.

Sentimentality Is Avoided

Pure fact and logic are not the only methods used, however. An attempt is made to appeal to every incentive bearing on the case. Sentimentality is avoided as much as possible but there is no hesitancy about using sound sentiment. And an appeal is made to self-interest as well as to humanitarian impulses.

This gamut of appeals is well illustrated by the advertisements used in this year's Hospital Sunday campaign. There was one advertisement on "Emergencies"—the lightning bolts that may strike anyone unawares. At such a time a hospital, well manned and well equipped, becomes a community's most important asset.

Another advertisement was a gentle but businesslike reminder of the time, always imminent, "When you or yours go to the hospital."

An advertisement on "Contagious Diseases" was a plain talk on the protection the hospital offers to the city's health.

At the other end of the scale was the advertisement on the little lad who was up against "Hard Luck," and who was dependent upon "invisible friends." The appeal to parental instinct, if not made mushy, is one of the sure strokes that can be depended upon to prompt action.

On the same theme, but in more playful mood, was an advertisement on "Stork Time." Here is where a hospital, even if not needed for any other purpose, comes close to the hearts and interests of a community.

Such subjects provide the dramatic setting for conveying messages about the hospital, which is not a begging organization, but a busy, efficient and human institution, doing a benevolent and humanizing work that Evanston could not and most assuredly would not wish to be without.

And responses came, as come they must, and as they have come each year. But the campaign is never done. In a community besieged by scores of appeals for worthy objects of every sort, human nature gets calloused. And so Hospital Sunday is never launched without a preliminary stirring up of community interest, which makes the hospital for the time being the biggest thing on the horizon.

Saving Money by Correct Use of Soap

What is soap? How many hospital superintendents know anything about its properties and adaptabilities? Yet such knowledge is essential in the economical running of a hospital, Dr. Warren P. Morrill, superintendent, Columbia Hospital for Women, Washington, D. C., points out in an article in the *Trained Nurse and Hospital Review*.

"Soap is a result of a chemical combination of an alkali and a fat," Dr. Morrill writes. "The alkali may be either sodium as in hard soaps, potassium as in soft soaps, or even ammonium as in some so-called dry cleaners. The fats used vary from olive or coconut oil for the finest toilet soaps, to tallow or cotton oil for the less expensive soaps.

"Five general classes of soaps are necessary in the hospital. Toilet soap is usually of the floating variety. This soap is rather soft, and is marketed in bars weighing from three-fourths of an ounce to eight ounces a bar. It is advisable to purchase this soap long ahead of the time it is to be used so that it may be dried out and hardened, since there is a great percentage of waste experienced in the use of soft soap. For the use of patients it has been found that the one and a quarter or one and a half ounce bar is most economical.

"Laundry soap is a soda-tallow combination usually furnished in chip or powder form. The best chip soaps contain about 88 per cent pure soap, the powdered soaps about 92 per cent. Soap powders are essentially a combination of a soap powder and a washing soda, and usually contain some free alkali. They are suitable only for washing hard surfaces that will not scratch. Next, the scouring powder which is merely soap with an abrasive material added, should be added directly to the surface being washed, as the soap will dissolve and the powder settle to the bottom if it is mixed with water. Last is the yellow laundry soap, of cheaper composition yet containing sufficient free alkali to make it particularly effective in washing cooking utensils and greasy vessels."

Following Up Accounts

If a patient is discharged before his account is settled, bills or reminders should be sent to him every two weeks, and if there is no response, a personal letter should accompany the third letter, according to F. O. Barz, business manager, Bethesda Hospital, Cincinnati.

"If there is no response to the third letter," says Mr. Barz, "another stronger letter should be sent two weeks later. We have found that certain form letters prepared by collection agencies are helpful in making collections. Sometimes it is well to use the stationery of the attorney of the hospital for the letter accompanying the statement."

What the A. C. of S. Expects of the Teaching Hospital

A Paper From the American Hospital Association Meeting

By MALCOLM T. Mac EACHERN, M.D., C.M., D.Sc.

Associate Director, American College of Surgeons, Chicago

THE plan of hospital standardization aims at creating an environment in the hospital that will aid the doctor and his associates in rendering the most efficient service to the patient.

The requirements are well known. They are simple but fundamental, minimal, but point the way to the maximal, voluntary but keenly sought after by all progressive hospitals, universal in their application and not restricted to any particular type of institution caring for the acutely ill. They are principles, not fixed details that inhibit initiative. They are reasonable and practicable in their application.

Naturally we expect to find the principles of hospital standardization carried out to a superlative degree in every teaching hospital in America, but we are sometimes disappointed in this respect. It must be said, however, that teaching hospitals have generally more than met the minimum requirements, notwithstanding some irregularities in carrying out the details. Perhaps if the above statement were not true the now historic 1918 list of approved hospitals might have been less than 89, or 12.9 per cent. But there has been rapid progress since that time and now 1800 hospitals, or approximately 70 per cent of those of thirty-five beds and over, have accepted the doctrine of hospital standardization, teaching hospitals contributing almost 100 per cent of their number.

Some Hospitals Near Borderline

Frequently some of the teaching hospitals are perilously near the borderline in meeting the requirements. At the present time we have two teaching hospitals under consideration for approval and it is exceedingly doubtful whether they should be admitted to the approved list for 1928. In one instance there has been a more or less general failure to comply with the requirements in an acceptable manner, whereas in the other, serious physical conditions exist that cannot be overlooked. I refer to the extraordinary practice of placing two patients in one bed, a

custom which I thought had passed with the dark days of hospitals of which we read in history.

This condition is no fault of the superintendent or officials of the institution, but is forced upon them by the state through insufficient financial support. The institution in question has so many outstanding virtues that overshadow the extraordinary condition referred to that it is difficult not to grant it official recognition. We always endeavor to weigh the whole evidence rather than a part in coming to a final conclusion but in this case the physical condition described cannot be overlooked. Finally, let me again emphasize the fact that the American College of Surgeons expects all teaching hospitals to meet the hospital standardization requirements not only in a minimal but in a maximal degree.

Better Hospitals Is the Aim

The program of hospital standardization should have the sympathetic interest and active cooperation of all teaching hospitals, which must realize that it is a program of fundamental principles for hospital betterment. An institution of this kind with its superior development and master minds should not be so self-centered or narrow-minded as not to see the greatest good for the greatest number in the promulgation of a program that has for its aim the betterment of hospitals.

While the attitude of teaching hospitals towards the program might be described as varying from enthusiastic interest and active support to apathy and indifference, the latter applies only to a small group, probably less than half a dozen. The majority are not only interested and sympathetic but actively cooperate in the work. The small group mentioned might be described as taking the "high brow" attitude that the program is not of sufficient consequence to bother with.

It is not difficult on entering an institution to interpret or diagnose its attitude towards the hospital standardization movement. We always make careful observation in this regard. Where there is apathy or indifference it will usually be

found that the same spirit characterizes the institution in all its relations.

Teaching hospitals should exemplify the tenets of hospital standardization and should lend their active cooperation to promote the movement throughout their community or state. It is reasonable to look to the teaching hospital for leadership. With its special resources it can assist other hospitals in reaching the ideals and standards of present day developments in hospitalization. Much has been done by many of you who are directing the destinies of these master institutions. With your leadership and beneficial influence much can be done to promote more efficient hospitalization generally, and the status of the teaching hospital will be more highly appreciated by the medical and hospital professions.

Cooperation Between Hospitals Urged

We need less competition and more frater-nalism in hospital work today. There is needed more of the spirit of the "big brother" movement. Friendly, tactful counsel and a cooperative, consulting attitude mean much in promoting better ideals and standards and act as a deterrent to improper procedures that unfortunately exist in some hospitals. If the teaching hospitals will recognize their opportunities and responsibilities in this respect, much more could be done to increase the genuine usefulness of all hospitals. Here is the challenge. Will you accept it, or do you prefer to live unto yourself, not allowing your radiance to shine forth and benefit the weaker members of this rapidly growing hospital profession?

The American College of Surgeons particularly urges teaching hospitals to take advantage of their early and intimate contact with the medical student and intern, to teach them at least the fundamentals of ethics and possibly of hospital administration. This would be greatly to their advantage in their future professional careers and in their association with other hospitals. Many of them are raw recruits in this regard when beginning their training or professional careers. In this way much could be effectively done in the formative years of their careers that might be impossible later.

The importance of ethics as a substantial part of the doctor's equipment cannot be overestimated, but unfortunately he has not always had an early opportunity to learn the proper dogmas on this subject. Perhaps if this were done systematically by teaching hospitals the problems of fee splitting, commercialism, unnecessary surgery and other discreditable practices might be reduced to a minimum. This seems to me even

more important than technical knowledge, for I do not see how any doctor can be regarded as efficient who is not ethical. The subject of ethics should have a definite place in the medical curriculum. Here the teaching hospital by precept and example has another opportunity and responsibility.

It has been a frequent surprise to the American College of Surgeons to find teaching hospitals without by-laws, rules and regulations covering their administrative and professional policies. Frequently these are not only lacking but there exists a feeling that they are not necessary for this type of hospital. I do not see how any institution can carry on efficiently without up-to-date by-laws, rules and regulations, setting forth its organization, duties, responsibilities, relations and procedures in a general manner. This is necessary, not only for continuity of service but for the smooth running of the institution. Every hospital should have its constitution, by-laws, rules and regulations carefully compiled and assembled in a comprehensive manner, revised frequently to keep them up to date, signed by those who must abide by them and readily available throughout the hospital for reference at any time. These should not be too detailed but should rather be statements of guiding principles that will unify procedure and control performance along the best lines.

Staff Organization Weak

It may be surprising to know that we occasionally find teaching hospitals weak in the organization and functioning of their medical staff. From the standpoint of staff organization teaching hospitals are of two distinct types. First the institution where the medical staff consists exclusively of the medical school faculty; in other words, only members of the teaching group are permitted to work therein. This might be designated as the closed teaching hospital. Second, the institution wherein both teaching and non-teaching groups are permitted to work. This might be regarded as the open teaching hospital. In some instances the members of the nonteaching group are carefully selected and limited in number. In others, little care is given to selection or limitation in number.

Generally speaking, when the staff consists exclusively of the medical school faculty we find efficient staff organization, consisting chiefly of well organized clinical departments with outstanding heads who are responsible for the work of their respective departments. The only deficiency noted in this type of organization is the lack of coordination of departments. Sometimes

the predominance of one department, due to aggressive leadership, may overshadow the other departments so as to upset the clinical balance, a condition that might not promote uniform interest and efficient functioning of the staff as a whole. Therefore, the factor of coordination of clinical departments in teaching hospitals should have more consideration.

Staff organization in the second type of teaching institution is a more difficult problem and one in which many hospitals are deficient. Not infrequently the teaching and nonteaching groups in this institution cannot be properly assimilated, particularly when antagonism exists. Generally we find the teaching group well organized into departments as above described, and the nonteaching group excluded from the organization. Further, it is not unusual to find the teaching group not assuming any responsibility, supervision or control over the work of the nonteaching group, consequently the professional efficiency of the hospital is lowered. This type of staff organization is practically the weakest we encounter in the entire hospital field.

Finally, it may be conceded that when the staff of the teaching hospital is limited to the faculty of the medical school it is well organized and functions efficiently if properly coordinated. On the other hand, when a teaching hospital admits the nonteaching group in limited or unlimited numbers, in addition to the medical faculty, the staff organization is weak unless extended to include both groups, at least so far as

control of the hospital's clinical work is concerned.

Staff conferences in teaching hospitals do not always provide for a thorough analysis of the clinical work. The staff conference as recommended by the American College of Surgeons has

a threefold purpose:

(1) the keeping of the professional work on the highest possible basis of efficiency; (2) the providing of a means by which all members of the medical staff may add to their scientific knowledge; (3) coordinating and correlating the clinical work of the hospital for research purposes. In the teaching hospital the analysis of clinical work is usually done by each department separately and it is difficult to carry on successfully the general conference, which is valuable in broadening the clinical viewpoint of members of the staff pursuing the different specialties.

The tendency for each clinical department to exist as a separate entity is not conducive to progressive medicine. There should still be a place for the general conference, where at least cases of interdepartmental interest could be discussed and a more general review of the work conducted. Too frequently in teaching hospitals the discussions are limited to interesting cases rather than to morbidities and mortal-

A Working Schedule

Every teaching hospital should meet the requirements of the American College of Surgeons, not only in a minimal manner but to a superlative degree.

The attitude of the teaching hospital towards hospital standardization should be one of active cooperation in furthering its tenets.

The teaching hospital should assist other hospitals in its community or state and should exercise leadership in promoting all movements for hospital betterment.

The teaching hospital, because of its early and intimate contact, should endeavor to inculcate into the medical student and intern the fundamentals of ethics and hospital procedures.

The organization of the medical staff in teaching hospitals should be improved with a view to better coordination of clinical departments and control of all the professional work.

The teaching hospital should provide for a systematic analysis of the clinical work, to be carried on in such a manner as will be of the greatest benefit to all doctors in the institution.

Case records in teaching hospitals, particularly when there is a nonteaching group, are generally found deficient and should be greatly improved and better supervised.

There is need in teaching hospitals for closer supervision over the clinical laboratory work done in the ward or unit laboratories by interns and residents.

There should be better supervision over the emergency or initial treatment of traumatic cases in teaching hospitals.

ities, which should always have prior consideration. Morbidities and mortalities that should not have occurred may be passed over lightly unless taken up in the clinico-pathologic conference. Sometimes the chief of the department may be hesitant in bringing up his own case. That is

why the general conference may be more valuable for review of morbidities and mortalities if it can be made interesting to all.

Where the staff consists of the teaching and nonteaching groups frequently only the teaching members are permitted to attend the conference, and the work of the nonteaching group does not come under proper review and analysis. This is a decided weakness in a number of teaching hospitals, and I have known of numerous instances where inefficient scientific work was being carried on under such conditions. Further, this latter group misses the constructive and controlling influence of a good staff conference. Provision should be made for all doctors privileged to work in the hospital to attend the staff conference and take part in the proceedings. Much, therefore, remains in many instances to make the staff conferences of teaching hospitals all they should be and in accord with the requirements, which you will find fully described on pages 7 to 29 of the January, 1928, *Bulletin of the American College of Surgeons*.

More Supervision of Records Needed

Case records in teaching hospitals where the staff consists entirely of the teaching group are generally of a superior type, with the exception of deficiencies sometimes found in connection with private patients. In the teaching hospital with teaching and nonteaching groups, the records on pay cases are frequently deplorably deficient. Some of these hospitals entirely fail in providing records for private patients and thus fall far below the nonteaching institution in this regard. In addition, there is often found a distinct lack of supervision of case records. These matters should have the serious consideration of all teaching hospitals, and records of a superior quality should be produced in all instances.

Generally speaking, we find excellent diagnostic and therapeutic facilities, such as clinical laboratory, x-ray, physical therapy, electrocardiograph, available and under competent supervision with efficient technical service. Occasionally we find lack of proper supervision of the ward or unit laboratory where the interns or residents do their work. Their findings are not always properly checked up, which might lead to serious errors in diagnoses. It would be well to place these laboratories under better supervision.

The American College of Surgeons is particularly interested in the care of the injured. A survey of hospitals reveals the fact that in many teaching hospitals much of this work is done by the intern or resident, with little or no supervision by the chief of the department. This may

not always be best for the patient, and it is therefore advisable that this work be under better supervision.

The problems here discussed are of major and minor importance and are submitted for the sole purpose of stimulating greater efficiency in the teaching hospitals of the United States and Canada, of which we are all justly proud. In the last analysis, while the major function of these institutions must be teaching, the right care of the patient should come first, last and at all times. It is from that viewpoint this subject matter is presented.

Instruction for T. B. Patients Urged

That some effort towards rehabilitation is imperative for tuberculous patients is evidenced by the difficulties that many patients encounter in making the transition from the "cure" to normal industry, according to Dr. Ernest Mariette, superintendent, Glen Lake Sanatorium, Oak Terrace, Minn.

With this end in view, the Glen Lake Sanatorium shops, using as much machinery as possible in order to reduce the amount of physical labor, will in the future provide teaching facilities for the practical work in various vocations suitable for the ex-patient. The theoretical work will be done in the ward during that long period of bed rest that follows the disappearance of toxemia. This plan will require close cooperation between the medical staff and the occupational therapy department, in order to prevent relapses from overexertion, either physical or mental, during the training period.

In addition to the training of patients in the numerous lines of work, the sanatorium will furnish an abundance of material for the training of laboratory, x-ray, and dental technicians. Some of the departments will be self-sustaining to a certain extent, but care will be taken to prevent the prescribing of occupational therapy in the shape of maintenance work for the purpose of obtaining cheap labor. However, when a patient can do maintenance work, it is well to allow this, for if he really is interested in it, it will serve to relieve him of a certain amount of personal worry, as well as fit him for the post-sanatorium competitive-world.

Making the Patient Safe From Infection

At St. Luke's Hospital, New Bedford, Mass., there is a new sixty-five bed children's unit. The ward service is arranged in cubicle form with a seven-foot partition between each bed. The lower three feet of the partition is of solid asbestos and the upper half of glass. Between each cubicle is a lavatory, which projects out into the ward, where the nurses, doctors and attendants are required to wash their hands before handling each case.

Many hospitals are increasing their efforts to prevent the spread of disease within the institution by installing lavatories at frequent intervals in the corridors and other convenient places so that the doctors, attendants, and nurses will be constantly reminded that their personal cleanliness is a vital factor in the success of this effort.



Martinsville Sanitarium Is Remodeled Into Compact New Unit

By WILSON B. PARKER

Architect, Indianapolis, Ind.

THIRTY miles south of Indianapolis, Ind., the quiet little city of Martinsville nestles among the hills in a section of the country famous for its scenery and for its mineral waters. A dozen or more sanitariums are found here, chief of which are those owned by the Martinsville Sanitarium Company and the Home Lawn Mineral Springs Company.

Each year has increased the number of those seeking the curative powers of the springs near the Martinsville Sanitarium, making necessary a proportionate increase in the size of the plant. Additions were made to the original building, new wings were constructed, and other improvements were made, until even these became inadequate and the Home Lawn Company, owners of the sanitarium, decided to remodel and rebuild the entire plant. This was three years ago.

To handle these improvements without disturbing the operation of the plant, a new bath house wing was built. This contained thirty rooms, in addition to the baths, as well as doctors' offices, laboratories, waiting rooms and other facilities for observation and treatment. Last year the work of remodeling the entire plant was started, many of the older buildings were demolished and the new structure was opened in December, 1927.

Those who have seen the transformation of this

institution from its collection of nondescript buildings into one complete unit, regard it as an example of unusually successful remodeling.

The new building has a frontage of 272 feet, occupying an entire block frontage, and is of substantial brick and semifireproof construction. An extensive front corridor leading from the portecochère to the main lobby, with parlors, music room, card and billiard rooms near by, offers abundant space for promenades, sunlight for invalids, and opportunity for social recreation. A private rear corridor provides guests with access from rooms to the bath houses.

The bath houses are modern in every way, with tiled floors, marble wainscot and partitions. They are well ventilated and well lighted and are equipped with solid porcelain tubs, steam and shower rooms, enema rooms, provisions for electric and x-ray treatments, all in direct communication with the doctors' offices and waiting rooms.

The medical staff has its own laboratory and drug rooms and modern equipment for analytical work. Three physicians, a matron, and a full corps of nurses are constantly on duty.

In the planning of the bedrooms, especial attention was given to lighting and ventilation. With their spacious closets and toilet facilities the rooms are equal to those found in any modern



hotel. Special features include the double-slat doors and special hinges for the solid doors, which permit the doors to open all or part way without slamming.

There are more than a hundred bedrooms, many of them double and all of them comfortably furnished and carpeted.

The dairy farm, operated by the company under state and government supervision, supplies fresh milk and butter to the sanitarium.

In outward appearance the sanitarium is an artistically designed structure in texture brick with

half timbered gables. The entrance porch is floored with quarry tile and decorated above with a wrought iron balcony.

The shaded spacious lawn, bordered with hedges, and filled with canopies and swings in the summer months, is an ideal place for rest and relaxation.

A country club and golf course are also part of the establishment. The golf course is one of the most beautiful in the state and attracts many golf enthusiasts who drive over for week-end visits with their friends who are in the sanitarium.

The fixtures and furnishings of the sun room and lobby are of most modern design and add a great deal to the comfort and convenience of the guests.



Linking the Dietary Department With the Administration*

By LULU G. GRAVES

Consultant in Diet Therapy and Plans for Dietary Departments, New York

APPARENTLY the relation of the dietary department of the hospital to the administration varies to an extent approximating the number of hospitals in operation. About all one can hope to do in discussing this subject, therefore, is to outline the conditions prevalent in the average hospital, point out the accomplishments of a few specific institutions, and offer suggestions for making this department of greater moment to the administration, all of which are possible of accomplishment in any well managed, progressive hospital, large or small.

Food Service Often Unsatisfactory

The committee on dietary service and equipment of the American Hospital Association a few years ago secured data showing that about 50 per cent of our hospitals have a satisfactory food service and about 50 per cent have not, with no distinction as to size and location of hospital. Though this was three or four years ago we are safe in assuming that these percentages still apply.

The departments giving satisfactory service, whether large or small, were generally well equipped and comparatively well planned. In the majority of instances they were found in organizations where all departments were working together intimately and harmoniously and they were contributing no small part to the health, happiness and morale of the hospital family. In view of this fact it is somewhat of a reflection upon those who are responsible for hospital policies and upon the dietetic profession that half our hospitals have unsatisfactory food service.

This high percentage of inefficiency may be attributed largely, first, to the lack of any standard in the dietary department as a whole, and, second, to the lack of discerning attention in the individual institution. The standardization movement has been instrumental in bringing about many improvements in hospitals and it is unfortunate that the dietary department has not been

included in this movement. At the time of its inception, possibly, the profession was not sufficiently developed for a plan to be presented. However, this is no longer true.

A group of alert members of a hospital staff do not need the whip of standardization to spur them into action, and many instances can be cited of excellent dietary departments. The fact should be stressed that in a dietary department where good service is given it will be found that the dietitian is given authority commensurate with her responsibilities. She is not overloaded with duties of administration, or expected to perform numerous routine tasks that interfere with her more important duties. The regulations governing her domain are shown the same respect and consideration that prevail in other parts of the institution.

Team Work Is Essential

At a meeting of the American Dietetic Association we were told that we are the youngest member of a team of eleven—useful, possibly necessary to the hospital, although many institutions have existed for years without dietitians. We all know if one horse in a team does not do his share he impairs the effectiveness of the others and fails to render the service expected of him. Patience and ready adjustment are essential in team work and a common criticism of the dietitian is that she does not adjust herself to the team.

In the instances of this lack of coordination that have come under my observation the dietitian is sometimes at fault and sometimes not. There will be no lack of cooperation if all members of the team are competent to do the job they have undertaken and possess the intelligence and cultural instincts to enable them to meet whatever the day brings. If they are interested in their organization they will have no time or thought for jealousy and will be able to discuss their difficulties calmly and adjust them fairly. It is the province of the superintendent to bring about such conferences when necessary.

Hospital superintendents frequently say, "I give my dietitian every opportunity to develop her

*Read before the New Jersey State Hospital Association, Atlantic City, N. J., May, 1928.

work as she sees fit but she has no initiative, she cannot take responsibility, she is extravagant, she cannot cook," and similar criticisms. If she cannot do these things this is a legitimate condemnation, of course. There may be extenuating circumstances, however, which will be mentioned later.

Little justification exists for anyone, man or woman, to seek or to accept a position he or she is not capable of filling, although we know this is done. Since we cannot change human nature let us confine our attention to some possible solutions of the difficulty. An eminent superintendent once said to me, "Frankly, I confess that I do not know how to use my dietitian. I have no idea what to expect or demand of my dietary department, nor do I know what I should do to develop it." This problem is not confined to one superintendent.

It has been repeatedly demonstrated that an unsatisfactory food service costs more than a satisfactory one under competent control, the difference in cost being in direct proportion to waste and extravagance. An efficient business organization having 30 to 40 per cent of its expenses incurred in any one department gives to that department intelligent supervision and adequate facilities for work and then demands results. Results in a dietary department should mean good food, properly cooked and well served, to every unit in the house at a cost commensurate with the hospital's finances. The food must not only meet the nutritive needs of the patient but must satisfy, at least to some extent, his personal desire. It should form the basis for some contact with the metabolic patient that will help him to an understanding of proper eating habits.

Nurses Need Instruction in Dietetics

If there is a training school the nurses, both before and after graduation, should receive instruction in dietetics that will enable them to serve a patient's tray with the same skill and intelligence they devote to other duties. It is a truism that few nurses in a private home can serve a patient's tray acceptably and that their attempts to do so are apt to upset the whole household. If a nurse were taught dietetics in such a way that she could grasp its significance she could probably serve her patients better and still be able to pass the state examination.

Instruction to nurses in this subject has not kept pace with advances in diet therapy in the medical world and with the knowledge of foods acquired by the layman. Of necessity the period of the nurse's training in the dietary department is short, and rarely is this training supplemented

in the wards or elsewhere. As a result, by the time she graduates she has forgotten a greater part of what she has so hurriedly learned and she is not interested in reviewing it. We cannot hope for more time to be given to this subject with the present crowded schedule of nurses' training but the time given the subject might be utilized to better advantage than it frequently is, and the schedule might be so arranged that a part of the instruction would be given in the senior year.

Never before have we had so much interest in better education for dietetic work. The majority of dietitians today have a college degree, many have a master's degree and some half dozen or more have a Ph.D. Every year a goodly number return to school to study for an advanced degree. An advanced degree is in itself no assurance of ability to manage a dietary department. In fact it may be quite the contrary if experience has been confined exclusively to the campus. It is, however, a preparation for assisting physicians or food chemists, and such students of nutrition do much to extend knowledge beyond the laboratory.

How the Small Hospital Can Help

Public interest is stimulated by health articles and articles on diet in the public press and popular magazines and these articles are the only source of information for large numbers of people. The hospitals through their doctors, dietitians and nurses should strive to arouse the interest of the nonprofessional reader and help him to discriminate between the authentic and the pseudoprofessional. This is particularly the province of the small hospital because here the various departments have a closer contact than is possible in the large hospital, and effective service can be given through the cooperation of the above mentioned groups, provided the dietitian's time is being utilized to the best advantage and the nurse is given a working knowledge of dietetics.

These are the things we may expect and demand of the dietary department. Now as to what the administration should do to develop the department.

First of all, it is desirable to coordinate all the forces employed in educating and training dietitians. There is a definitely outlined, rigidly enforced program for training medical students and nurses, yet the training offered to student dietitians varies with every hospital. All too frequently is this training offered merely as a means of meeting individual difficulties and the student gets experience only where her services are

needed. Opportunity for experience or instruction in more than one or two departments is to be had only in a minority of hospitals and specific instruction from the chief dietitian or other members of the staff, either in the form of lectures or demonstrations, is rarely given. Seldom is the dietitian given the opportunity to learn even the rudiments of buying food or equipment, nor is she taught cost accounting. Yet she is expected to be conversant with all of these matters when her training is completed and she is employed by another hospital. Her failure to understand them is denounced and the profession is accordingly condemned.

For this and several other reasons the majority of colleges are not encouraging their graduates to go into hospital dietetics and little attempt is made to prepare them for this field.

Courses Often Inadequate

No hospital should offer a postgraduate course to prospective dietitians until it can give a course that will prepare them to meet in a fair measure the responsibilities they will be called upon to assume in another hospital. When this is done dietitians can command the cooperation of the colleges to the extent of having this subject given consideration in the curriculum, and the percentage of unsatisfactory service will be reduced to a perceptible degree.

When a recently graduated woman is engaged it is wise to learn something of the training she has received. Too often we assume that she is well trained because she was trained in a hospital of good standing, and too often this is not the case. Hospitals giving a wholly inadequate training to student dietitians are as numerous as those giving an adequate one, and they are continuously sending young women out to positions for which they are not suited. This is obviously unfair to the young woman who gives evidence of her good faith by completing the college course and taking the prescribed work in a hospital. It is equally unfair to the hospital that employs her.

I am compelled to disagree partially with the committee on dietary service and equipment of the American Hospital Association in its report for last year which states: "If we set out to give a course to students we must treat them as students, not as apprentices. We must protect them from unnecessary routine and we must give them a well rounded opportunity to meet the professions so closely allied to theirs in the service to the sick. We must protect the hospital from their mistakes by having enough employees in the dietary department to make this unit function properly." Do we protect the medical student from

routine? Ask any intern. Do we protect the hospital from his mistakes at the expense of his training?

More and more hospital administrators are asking for dietitians with executive ability. This is as it should be. All agree that intensive care of the diet of the metabolic patient is necessary; that intelligent food service to all other patients is desirable, and that for the personnel good food, well cooked, served in as great variety as the finances will permit, is a duty. Supervision of all this demands a person of mature judgment and executive ability, with a thorough knowledge of foods and cooking. Can such a one be found? There are a few such extant but the demand far exceeds the supply, and the hospital is meeting keen competition for their services from the business world. Interest in nutrition is so widespread that there are many opportunities for the competent woman to do worth while work under less trying conditions than are found in the average hospital.

Dietitians are accepting positions in the commercial field chiefly because of the greater freedom it gives them to make use of their education and experience. On the whole the remuneration is no greater and some of them would prefer to stay in professional work if desirable positions were available.

Kitchen Planning Vitaly Important

Another feature calling for intelligent attention is the physical arrangement of the kitchen. Improvement in this direction is already apparent. Thus far the improvement has been chiefly in equipment. Kitchens are being better equipped, more completely equipped. Equipment houses have been prompt in recognizing the trend and are improving existing equipment and utensils and providing new equipment in generous quantities.

Plans for the kitchens and allied rooms should always be passed upon by some one familiar with the daily activities of the department. The architect and equipment man are necessary in making these plans. Both are familiar with factors of construction that are wholly unknown to the majority of dietitians and chefs. On the other hand, there are numerous things that seem of minor importance to these men which assume major importance during the preparation of meals, and there are factors that may do much to promote or to hinder expeditious service that never occur to one who is not familiar with actual cooking processes. Too much stress cannot be laid upon the placing of equipment to facilitate work. Irregularity of meals is an unpardonable

offense in a hospital and has far-reaching effects, therefore, arrangement of workrooms and of apparatus should be such that a minimum of time and effort is required for all activities.

The favorite place for the dietitian's office seems to be adjacent to the dishwashing room, or in a similar noisy place. Here she must have interviews with assistants, salesmen, employees and others. Here telephone calls must be received and heard, menus prepared, classroom work, cost accounting and numerous other tasks accomplished, with no semblance of quiet or privacy.

Classrooms for teaching dietetics to nurses frequently are provided with only one sink for a class of twelve. In this one sink each and all must wash vegetables and fruits at the beginning of the period and then must wash their dishes at the end of the period. In a two-hour period there is little time left in which to teach food preparation, principles of cooking and serving and the application of these principles.

To summarize: When the dietary department is supervised by a person with ability, who can convince the hospital authorities of her worth, a good start has been made for establishing a department worthy of recognition. This recognition includes, among other things, that the one in charge of the department shall have authority commensurate with her responsibility, and that this authority shall be respected to the same extent as that of other heads of departments; that the working conditions, living conditions, hours of service and compensation shall be proportionate to that of others in similar positions; that the department shall have a representative voice at staff meetings and that it shall be given a place in the annual report.

Social Worker Fills Niche of Family Doctor

The social service worker is coming more and more to take the place of the old family doctor as chief adviser and counselor of the family whom sickness has visited, is the opinion of Dr. Newton S. Stern, Memphis General Hospital, Memphis, Tenn., as expressed in the *Bulletin of the American Association of Hospital Social Workers*.

"As our modern hospitals are organized, the relationship of doctor to patient is not this personal one, so social service has come into being to reach the heart and home of the patient and has taught the doctor the need of understanding the social background," says Dr. Stern. "Now social service should go a step further and supply this need in the relationship of the private physician and the pay patient. This new step will have to be a gradual one, for the patient's psychology is different in free and private groups, the private patient resenting the intrusion of a third person. However, it can come into

being through group beginnings in the hospital, such as that of a specialist physician. In an open staff hospital the most logical way is through classes for patients, such as food clinics for diabetics or shops for cardiacs. These should be under the direction of the hospital, but with a group of physicians to guide the policies, and patients should pay enough to cover all expenses, including that of a social worker.

"There are many difficulties in the way and a new technique will have to be developed, but this will come as the need increases."

Forced Air Evacuation in the Sterilizer

The following information on sterilizing technique in hospital surgeries is taken from an article published in a recent issue of the *Trained Nurse and Hospital Review*.

The process of sterilization should be closely watched and the person in charge of the apparatus should be on duty in the sterilizing room throughout the entire operation.

The materials that are to be sterilized should be carefully and loosely wrapped with one or more thicknesses of double weight factory cotton. They should be carefully dated with indelible ink, and so packed in the sterilizer that there will be plenty of room for the penetration of steam between the different bundles. This requires that the packages should not be placed in the container so that the flat surfaces make contacts, but so that the edges touch. In packing the sterilizer care should be taken that the packages will not touch either the front or rear walls.

At 250 degrees F., the lowest temperature at which sterilization should be attempted, it will take five minutes for the steam to penetrate thoroughly to the extreme center of every package. The slightest drop in temperature will increase materially the time required for thorough sterilization.

Of the various types of sterilizers the forced air method is said to be more dependable, though the vacuum type is used to a great extent. The reason for the preference of the forced air type is that nearly all the air is forced out of the chamber by the steam, whereas in the vacuum type sterilizer there is always a certain amount of air left with which the steam must mix, thereby lowering the temperature of the steam.

The procedure for sterilizing with the forced air type is as follows: All valves should be closed, the door should be locked and the water heated until the jacket gauge indicates twenty to twenty-two pounds pressure. The chamber drain valve should then be opened wide and steam allowed to enter the chamber. When a pure white cloud of steam is discharged through the drain valve it should be closed and steam allowed to enter the chamber until twenty pounds pressure is indicated on the chamber gauge. This pressure should be maintained for about thirty minutes, during which time the drain valve should be opened at about five-minute intervals to allow condensation to drain off. At the end of the thirty-minute period the drain valve should be opened wide to rid the chamber of steam. When the pressure gauge indicates zero the door should be opened slightly. The heat from the steam jacket will then vaporize the remaining moisture and the dressings will be dry enough for storage in about three minutes.

The Tired Nurse—What Can We Do for Her?

By J. J. GOLUB, M.D.

Director, Beth Moses Hospital, Brooklyn, N. Y.

IT IS the purpose of this discussion to bring into evidence the underlying causes of fatigue in nurses, which results from either bodily or mental strain and affects their efficiency. For in nursing, as in industry, it may be said that efficiency ceases where fatigue begins.

There are, indeed, reasons for inefficient nursing other than fatigue, but they are not pertinent to the present discussion. Inefficiency that results from unconscientiousness, negligence, undereducation, poor training or lack of common sense, is, to be sure, a problem for the attention of hospital administrators, but this can be corrected by replacement. Alongside of the problem of the alleged shortage of nurses, a problem now considered to be one of unequal distribution rather than of paucity, fatigue is the hospital's important concern.

Women More Easily Tired Than Men

Women, anatomically and physiologically, differ in several ways from men. Because of this they are more susceptible to certain diseases. Overwork of women in industry is said to bring about increased nervous disorders, lower birth rate, heightened infant mortality and an impaired second generation. It is therefore safe to assume that everything else being equal, women are more easily fatigued than men.

In considering causes of fatigue in the nurse we must examine factors that come from without, such as the physical conditions under which she works, the air, temperature, humidity, ventilation, light, noise, floor-walking distances, hardness of flooring, comfort stations and rest rooms. We must also take account of those factors that exist within herself—her general health and personal hygiene. It is important to know whether she has any chronic disease or susceptibility to frequent attacks of acute illness. Hours of sleep, rest periods, exercise, diet, bowel movements, smoking, drinking, drug habits, are all important elements to be considered. The fit of clothes and shoes, the condition of the feet, the posture and gait are factors that cannot be lightly regarded.

Important as all these are, they are not greater

causes of fatigue than the nurse's long hours of strenuous work, the character of her work and lack of interest in her work. Monotony, which is often given as one cause of fatigue in industry, is not to be regarded as important here. In nursing there can be no sameness of work, any more than there can be any two patients alike.

It is not sufficient, however, to know these obvious causes; one must also look for lassitude and weariness brought about by an improper mode of living. The nurse with an artistic temperament, for example, who prefers a classic residence in the antiquated and crowded Greenwich Village, is indeed having atmosphere but little air. Living normally when one is away from work is as important as proper performance when at work. The widowed nurse who does housework at night and rushes home to prepare supper and put to bed her fatherless child, and arises early in the morning to prepare breakfast before reporting for duty, beyond question starts her day with a handicap and ends it with anxiety. Her susceptibility to fatigue must be great. It therefore follows that a tired feeling should be traced to its source in order to determine whether it is due to the work of the day or to acts of the night before.

Poor Planning One Source of Fatigue

If all our hospitals were new, and if these new hospitals were planned by expert architects and qualified hospital consultants, many of the disturbing fatigue sources would be eliminated. Today modern hospital construction takes into account sunshine, ventilation and quietude. Grouping of buildings, allocation of rooms, and interdepartmental relationships are carefully planned so that there may be a minimum of internal traffic.

It is no longer expected of us that we shall repeat Joshua's miracle of ordering the sun to stand still, or that we shall focus the sun's rays at will for all hours and into all dark corners. Instead the axis of the hospital building is conveniently placed to accommodate the constancy of the sun. Hospital buildings scientifically grouped lend themselves to sunshine in most places at



Note the posture of controlled restlessness, the expression of deep anxiety, fear and worry that the subdued high tension of waiting causes.

Stretching upward requires much muscular effort. A nurse was seen to repeat this act several times in one hour. Incidentally her hands and sleeves were soiled.



The nurse is here seen crouching for a bottle of saline. Note the hand on the floor, supporting the body and making necessary immediate washing.



nearly all seasons of the year in this country.

Electrical engineers also give due consideration to the scientific installation of artificial lighting systems. They realize that a great deal of the nurse's work is reading notes and charting, which require good light so that there may be a minimum of eye strain. Proper light alone, whether day or artificial, will not always reduce eye strain. Some eyes are in need of refraction for proper accommodation to objects. The desire to be attractive is often not farsighted. The resentment to eyeglasses on the part of women is damaging to the eyes and to general health. Perhaps the solution to the problem lies in fashion. Someone ought to start a movement making eyeglasses as alluring and fashionable as earrings

or high heels. Manufacturers would profit by the sale of combination sets, such as green jade earrings and glasses with rims to match for the olive complexion, an amber set for the blonde, red for the brunette, and a black set for any type when in mourning. And perhaps, to make glasses more popular in childhood, pink would be for boys and blue for girls.

Ventilation, temperature and humidity when not properly regulated, cause general malaise, and with the taxing work of the nurse, poor atmospheric conditions often

make her windless to the point of prostration. Although vitiated air can be tolerated for hours without evidence of fatigue, with high temperature and high humidity, the discomfort is extreme and causes headache, nausea and even dizziness. It is an indisputable fact that poorly ventilated and overheated rooms lessen mental and physical activity. With pure air in gentle motion, temperature of 65 degrees F., and humidity of about 50 per cent, there is a feeling of freshness, restfulness and muscular tone. In his paper, "The Lost Art of Hospital Ventilation,"* Dr. Goldwater says: "The ventilation of a hospital is affected by the character, grouping and exposure of its buildings, by the arrangement of rooms and of

*THE MODERN HOSPITAL, March, 1924.

patients' beds, by the manner in which windows, doors and ducts are related to each other and to elevator shafts, corridors, stairways, beds, plumbing fixtures, ranges and sterilizers. . . . But the most important single element or influence in hospital ventilation is human behavior, and without a full understanding of the human equation in the case, successful ventilation is impossible."

Odors are not as a rule injurious to health, but they can be sickening. Of course with good ventilation the problem is lessened. Physical nearness is generally not welcomed by esthetic persons. One should be on guard against permitting a slovenly person to work in the proximity of nurses. We might learn a lesson from the resourceful executive whose business called for many office interviews, and who nailed the chair reserved for his caller to the floor, thereby assuring a reasonable distance between him and his guest. At times he must have pitied the fruitless efforts of his visitor to pull his chair closer.

Noises are annoying everywhere and especially in the stillness of a hospital. They irritate the nerves and cause restlessness. They distract attention and necessitate intensified exertion of "focalization and concentration." The sizzling radiator, leaking faucet, rattling window or slamming elevator door, annoy nurses more acutely than do the screams of labor pains or the hum of an x-ray machine.

Planning suitable diet for nurses, is a vexing problem. Food is no longer taken for nourishment but for form. Whatever the aim of eating might be, the period during which food is taken should be one of relaxation. It is desirable that eating be preceded and followed by a rest period. This calls for comfortable and convenient rest rooms. In this connection, it may be said that cafeteria service may be economical for the hospital but that it is not restful to the nurse. Handy comfort stations are also not without their beneficial influence.

There is a Slavic saying, "A gentleman is recog-

The proper height for the work table is shown on the right. Note the restful posture of the worker and the ease with which she seems to work.



The nurse need not exert herself to obtain supplies from a shelf at normal level. Everything is conveniently within reach and both time and labor are saved.



When the work bench is too low or the stool too high it becomes easy for the worker to assume the incorrect position shown in the picture on the right.



nized by his boots." And so is the intelligent nurse who wears well fitted shoes with toes not too pointed but with sufficient toe room and low heels. Rubber heels, says a commercial advertisement, reduce several thousand shocks to the spine a day. The comfort to others must be even greater, especially when nurses walk on hard floors. In one hospital I saw nine varieties of flooring, namely, tile, marble, cement, terrazzo, magnesia composition, rubber, cork, linoleum and wood. Each kind of flooring, of course, has its advantages and disadvantages and its proper place, but from the point of view of comfort to the nurse and patient and as a lesser source of fatigue, rubber, cork and linoleum are preferable to the harder types of flooring.

A Tired Nurse Is Like a Tired Child

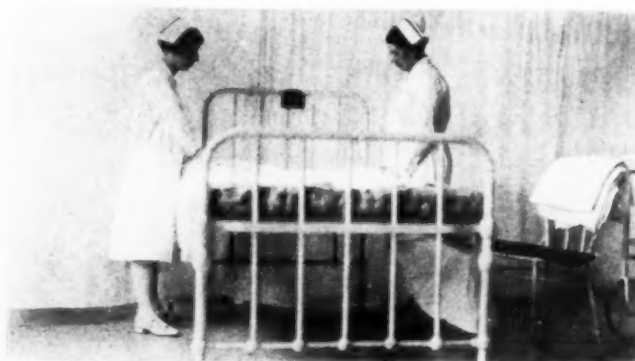
Many of the symptoms of fatigue in school children are often seen in tired nurses. Hesitant speech and strained tone, irritability on slight provocation, pale color with a peculiar type of flush, drooping posture and forward bowing of the shoulders and head, reddened lids and large circles around the eyes, headache and rapid heart, excessive perspiration and constipation, are often observed in the overworked nurse.

Nursing, which involves an endless variety of tasks, is bettered or degraded by the character and utility of the work assigned to the nurse. It is not only important to know what constitutes nurses' work, but the duties that are accepted to be those of the nurse should be carefully studied. The steps involved in each procedure or definite piece of work should be examined. Often such studies reveal considerable waste motion. Moreover unnecessary procedures come into evidence, and what is equally important, many faulty procedures are unearthed. Reducing the nurses' optimum load to essential and fruitful acts correspondingly influences the onset of fatigue.

The lot of the operating room nurse is so characteristic for its unique travails that for a moment it would be of interest to give it especial

consideration. It is ordinarily presumed by some surgeons that the operating suite and staff should, with an air of readiness, await their arrival. With the patient anesthetized, the operating field mahoganized and exposed, the aseptic nurse, gloved and gowned, with sponge in one hand and suture in the other, the second assistant surgeon playing with two retractors on one side of the patient, and the first assistant surgeon with scalpel ready to hand to the chief on the other side, the stage is set and the surgeon appears on the scene. He hurriedly changes to cap and gown and at once begins to scrub and whistle. Everything and everybody is in readiness and at attention for perhaps a half-hour or longer. Little does the surgeon realize what transpires in the minds of the entire staff while they are waiting for him, and the mental and physical strain which standing at attention and the restlessness of waiting bring about.

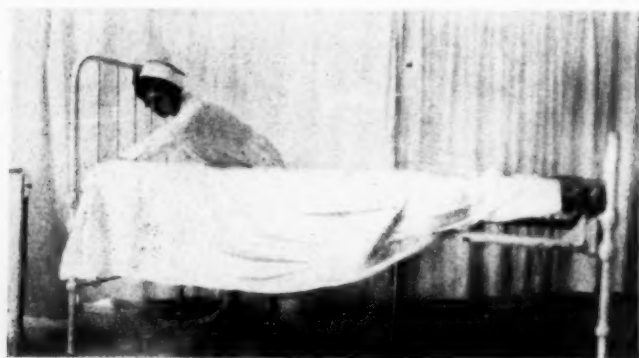
Speaking of industry, Josephine Goldmark quotes the Italian physiologist, Treves, as having stated the indisputable truth of the "illusory profits of long hours." Alert manufacturers are now realizing palpable profits of efficient labor during shorter hours. Parallel with this tendency, the nurse's work spell has indeed of late been reduced. The ideal, however, will be reached



Two can do the job with ease.

when hospitals introduce the eight-hour day—7 a. m. to 3 p. m., 3 p. m. to 11 p. m., and 11 p. m. to 7 a. m., with a rest pause of one half-hour at about the middle of the spell. Short hours are not tiring and carry with them contentment and cheerfulness. It is not questioned that work cheerfully done requires less vigilance and little supervision.

The practice in Great Britain of serving tea to clerks and other employees of the "white collar" class, at about 4 p. m. is not to be regarded as unwise. The few minutes taken for the cup of tea not only give contentment, but the pause and the beverage refresh the workers' energies at a time when fatigue is beginning to make its appearance.



One nurse must exert herself to make up a bed.

In this connection, the rule usually in vogue in hospitals prohibiting the nurse on duty to take refreshment on the floor or in the diet kitchen is not without disadvantages.

The rest pause has a beneficial psychological effect. To look forward to a long stretch of unbroken work is likely to damp the enthusiasm of even an ardent worker. Nurses, like all others, need psychological bracing. The introduction of rest pauses is in itself not sufficient. Nurses in their training days should be taught the technique of relaxation. Few people know how to relax mentally and physically. The technique, however,



The orderly should be assigned to move patients on stretchers.

can be readily acquired. Just as food relieves starvation and water quenches thirst, time and rest banish fatigue.

As far back as 1921, Elizabeth A. Greener, R.N., New York, made an interesting study of hospital nursing service*. In seven acutely ill patients she found that the average nursing care time per patient was four hours and forty-nine minutes during twenty-four hours. In 1926, Mildred Constantine in a similar study of nursing care of patients with chronic diseases, found that the shortest time a patient received was one hour and six minutes and the longest, six hours and twenty minutes. The average was four hours and fourteen minutes. Nursing is heaviest in the morning, becomes less heavy in the afternoon and still less heavy during the night. There is, in fact, a direct and important relationship between the number of hours of nursing care each patient receives and the course or outcome of sickness. In the nursing care of infants, it is known that where the number of patients per nurse is small, each infant will be properly fed and kept dry and comfortable, thereby increasing resistance and reducing fatalities.

In a hospital for acute diseases, it is estimated that on the basis of a twelve-hour day for nurses, the best service can be given by a staff that permits a ratio of one nurse for every two patients.

*"A Study of Hospital Nursing Service." THE MODERN HOSPITAL, January, 1921.



The stretcher should not be at a lower level than the operating table.

On the basis of an eight-hour shift, the needs are slightly higher—one and one-third nurses for every two patients. Thus a hospital with an average daily census of approximately 200 patients would require a staff of 100 nurses for a twelve-hour shift and 133 nurses for an eight-hour shift, equitably distributed for day and night duty. In either case, the number does not include operating room and out-patient nurses, and the like. The proper number of nurses equalizes the load, reduces fatigue and benefits the patients.

Fatigue in nurses is costly not only in terms of money. That alone, indeed, swells the hospital deficit, but of greater importance are the consequences of deficient service to patients and the subsequent impaired health of nurses.

Absenteeism Follows Overwork

The ill effects of overworking nurses are said to be many. Absenteeism increases and the loss of working time, say of one nurse on a floor, taxes the energies of the others. The quality of the work is lowered and almost simultaneously with this there is an increase of complaints on the part of patients and members of patients' families about the character of the service. The quantity of work is reduced and important duties remain undone. The rate of sickness in nurses rises and the number of accidental injuries increases. And, lastly, the personnel turnover becomes great. Happy is the hospital that can say, "Our girls never leave except to get married." Weariness and dissatisfaction are the causes of many resignations. When a hospital is confronted with a large turnover of nurses, it is wise to pause and consider the conditions under which they work, the hours and the character of the work required of them. While no one can deny the fact that a goodly number of nurses have tastes and qualifications that do not lie in the direction of institutional nursing, and that some nurses resign because they feel drawn toward some other field of work, the majority would stay in one place under pleasant conditions.

Grading Meats for Veterans' Hospitals

By CAROLINE B. SHERMAN

United States Department of Agriculture, Washington, D. C.

FOR about a year the majority of the veterans' hospitals have had the benefit of expert, governmental meat grading in the purchase of their supplies, and the official grading has brought other benefits to the disabled soldiers and those who care for them.

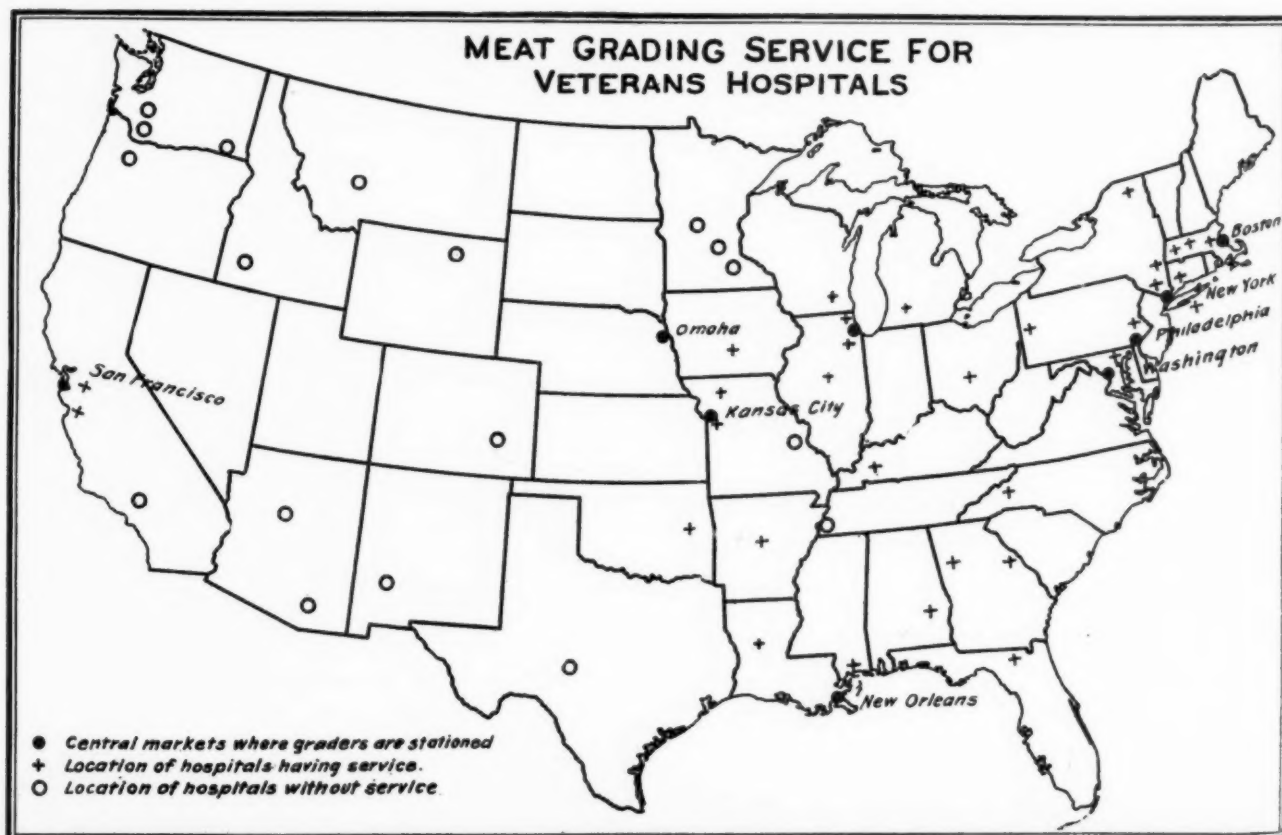
Begun in a tentative way at one or two hospitals, as a matter of cooperation between the United States Veterans' Bureau and the Bureau of Agricultural Economics in the United States Department of Agriculture, this work has now been extended to cover thirty-two hospitals, although in a few instances the service can be only occasional because of location. The grading includes all meats, meat products and poultry. Results have been so satisfactory that it is hoped eventually to cover all Veterans' Bureau hospitals.

This grading is to be differentiated from the official sanitary inspection of meats, which has

been long conducted by the U. S. Department of Agriculture. Grading has to do with quality, and official grading is conducted on the basis of standardized grades for the various meats. These grades have been worked out by the Bureau of Agricultural Economics and have been used in Federal market reports for several years.

In veterans' hospitals that are near large cities, where official graders are stationed, the service to the institutions can be complete. In hospitals at a considerable distance from such centers, occasional grading must be worked in when opportunity offers. The remaining institutions are so placed that they could be served only by a grader who could devote all of his time to the hospital work. The accompanying map shows the extent of the present service.

Although at times the grading must be done at the hospital, which means that any meats that



do not come up to specifications must be turned back from the door, every effort is made to do the grading at or near the point of shipment to prevent rejections that are expensive to the shipper. The grader's stamp on the accepted meat then notifies those at the hospital that the product fulfills the specifications. More and more, as contractors become familiar with the work, they are asking the graders to come into their coolers and help them make the selections to fill the contracts.

Naturally everything has not gone smoothly all the time but the complications have usually emphasized how much this work was needed, and determined effort and hearty cooperation between the two government departments involved have already brought about most satisfactory results. During 1927, the quantity of meat graded for Veterans' Bureau hospitals far exceeded two million pounds, and this year's work promises greatly to surpass that figure.

Effort has been made to conduct the work along educational lines, insofar as possible. Although there has naturally been some resistance among the contractors, the far-sighted ones have been quick to learn all they could from the graders, and after watching the work, several have frankly altered their ideas in regard to grades. Buyers and stewards for hospitals have often been more open to suggestions and have followed the graders closely, learning all they could about the elusive matter of quality in meats.

Specifications Better Understood

Much has been learned about specifications by all concerned. Bidders and contractors for these hospitals now realize that specifications are something to be followed and not ignored, as has happened all too frequently in the past; and the graders have been able to convince the hospital authorities in some cases that their specifications were too low, and in other cases that they were too high. At times the specifications have called for an exact kind of meat or chicken that could not be found on the markets at that time, thus unconsciously inviting silent substitution of lower qualities at top prices. If a grader finds that a delivery is below specifications, but is about as good as can be delivered under existing supply conditions, he may recommend that the meat be accepted but at a commensurate lower price.

One case is cited as an example of the work done. At a remote hospital on a two-day grading service, the grader had to reject entirely meat valued at \$254 by the contractor, because of unsatisfactory quality. He recommended the ac-

ceptance of the remainder of the shipment, but at a price \$378.58 lower than that quoted by the contractor, and this lower price was accepted.

To get an average of results obtained, a statement including five hospitals and covering two months, selected at random, shows a difference of \$1,181.61 in market value between the meat products called for in the specifications and those delivered but rejected by the grader. The amount might have been greater had not the graders been permitted, in several instances during these two months, to make selections for these hospitals in the cooling rooms of the contractors. This kind of service is not permitted by all contractors.

Graders Assist Local Hospitals

The acting medical director of the Veterans' Bureau has recently written the Bureau of Agricultural Economics to express appreciation of the fact that the graders often give assistance far beyond that specifically called for by the grading service. He states that on several occasions the graders have called the local hospital for disabled soldiers by telephone, to tell them when purchases can be made advantageously and when some special commodity that meets special requirements may be found on the market.

Can other hospitals benefit by this service? This is the inevitable question, and it has two answers.

Wherever these official graders are stationed their services are available to institutions at commercial rates, insofar as their other work permits. Several state and other hospitals have used the service. Dietitians and buyers from other hospitals have sometimes secured instruction from such graders through special arrangements.

Moreover in certain cities, Boston, New York, Philadelphia, Washington, D. C., Chicago, Omaha, Neb., Sioux City, St. Joseph and Kansas City, graders are now stamping prime, choice, and good grades of steer and heifer beef, on request of packers and slaughterers. Dealers at any point in the United States that is served by packers or slaughterers who have this service, can thus buy beef that is so stamped. The class and grade names are repeated along the carcass in such a way that practically every retail cut, from the round, rump, loin, rib, chuck and neck, will carry the stamp. This service has been conducted for a year as an experiment. Results have been so satisfactory that, beginning July 1 this year, it was made a permanent part of the department's meat grading work. Services of government graders will be available at all points where they are now stationed at the regular charge of \$2 an hour for the grader's time.

Solving the Middle Class Patient Problem*

By CHARLES F. NEERGAARD

Hospital Consultant, New York

IT WAS about twenty years ago that the individual known as the semiprivate patient first raised his head above the hospital horizon. Since then he has been a very troublesome person.

Twenty years ago life was not half so complicated as it is today. Our economic organization was on a simpler scale. If a man was well off, he was well off and we put him in a private room. If he was poor, he was poor with a vengeance and we put him in a ward bed. Those were the days before the war, when labor was just beginning to demand and get the higher wage and the shorter day, which were unquestionably its due.

When the average man, who in the past had worn brogans and a blue shirt, put on a white collar on other days than Sunday—that was when the trouble began. The hospital found that a new economic class was making itself felt. While not averse to taking advantage of the economy of the free service that the hospital and the medical profession generously and unquestioningly offered, the white collar man, beginning to feel his social oats, did rather resent being treated as one of the bread line, cared for as one of the crowd by the hospital physician, rather than given some privacy and permitted to have his own doctor. The medical profession also discovered that there were many patients needing hospital care who could pay something for it, yet could not afford a private room. However, as the average doctor could not follow the case into the wards, he naturally and logically cared for it at home.

The Semiprivate Patient Evolves

So, among both the medical profession and the public, there began a constantly growing pressure for what became known, for want of a better term, as the semiprivate bed. The semiprivate patient in the last decade has grown from a minor incident to a major problem. Who is he, what does he want, and what can we of the hospital field do about meeting his needs?

Back in 1921, when the Cornell Pay Clinic, New York, was started, a committee of sociolo-

gists and economists made a social economic study of the population of New York City, to determine how large the clientele would be from which the pay clinic might draw, or, in other words, how numerous were the self-respecting patients with moderate means who had but a small margin of income over the expenditures necessary for a minimum of comfort. The estimate of this committee was that more than half of the families in New York City had incomes of more than \$1,200 but less than \$3,000 a year.

Family Budgets Studied

Studies of family budgets made at that time resulted in an estimate that for a family of five with an income of \$2,000 a year, \$60 might be allowed for the care of health, that is, doctors' fees, medicine, nursing and dentistry. If more than this was expended for health care, the family must pinch in food, clothing, housing or some other necessity. How far would \$60 or even \$100 go for just a single case of serious illness requiring hospital care? As Dr. Michael M. Davis says, "Why go further? The problem affects the larger part of our population. It affects some of the people all the time, and nearly all of the people some of the time."

A distinguished committee of physicians, scientists and laymen are now undertaking a five-year study of what they call the "one great outstanding problem—the cost of medical care." Bulking large in this cost is hospitalization with particular emphasis on the group we are considering—the economic middle class.

Somehow or other hospital authorities do not seem to realize this need or do anything about it. Take New York City for example. Back in 1923 when Dr. Lewinski-Corwin wrote his book "The Hospital Situation in Greater New York," he found that in 104 nonmunicipal hospitals, with a total of 16,850 beds, only 2,696 or 16 per cent were set aside for semiprivate patients; 10 per cent were for private patients, and the balance, 74 per cent, were ward patients. Today, five years later, what is the situation? The nonmunicipal hospitals have increased to 116, with 21,123 beds, an

*Paper read at the meeting of the New York State Hospital Association, New York, May, 1928.

increase of 4,273. You would naturally think that, with the pressure and constant discussion about the need for middle class accommodations, most of these 4,000 new beds would be devoted to the semiprivate patients. As a matter of fact only a little over 10 per cent, or 576, have been added to this group, whereas 1,300 have been added to the number of private beds. In 1923, 16 per cent of the beds were available for semiprivate patients; today only 15 per cent are available.

It would seem that in New York City, with some 60 per cent of the population falling into the semiprivate class and but 15 per cent of semiprivate beds in the community hospitals, we were failing to meet our responsibility to the community as a whole. In every city and large town the pressure for these beds is becoming constantly more insistent. Housing conditions contribute to this. A critically ill patient cannot possibly be cared for properly in a three- or four-room apartment. Furthermore, the man of moderate means cannot afford medical and nursing care at home, since it costs more to have a private nurse at home than it does for the entire service in the hospital, irrespective of the better care and greater safety which the latter insures.

How Is the Young Doctor Affected?

There is another person who suffers from the shortage of semiprivate beds, and that is the young doctor. He may be on the courtesy staff, or in a large institution he may be a clinical assistant in the dispensary, with the privilege of getting his patients into the private and semiprivate beds, but in a hospital with accommodations for only a few semiprivate patients, what chance has he to get a case in over the prior claims of the attendings?

Probably no subject has been discussed more frequently and from more angles in the past five years than this one we are considering. As I see it, the proper care of the semiprivate patient involves changes in administrative policies, medical policies and nursing procedure, and certain adjustments in the hospital scheme of things, all of which have been tried out in one place or another

and have proved sound. Every community hospital, sooner or later, will have to meet these conditions. If eventually, why not now?

Assuming the great demand from this large and clearly defined class of patients, willing and able to pay a moderate price for good hospital care, seeking no charity and requiring the attendance of their own physicians, we have to determine three things: First, how shall we house them; second, what shall we charge them; third, how can we give them the service they should have at a price they can afford to pay.

Shall They Be Segregated?

First, how shall we house them? Various suggestions have been made, that savor of segregation, such as, building a separate semiprivate pavilion or setting aside special floors. This means merely adding one more specific unit and inflexibility, which always represents a source of operating waste and expense. If you have a separate semiprivate pavilion, you are simply labeling these patients in an undemocratic manner and isolating an economic group. One ideal arrangement, in my judgment, is represented in the plan of a new 350-bed hospital. It is a seven-story U-shaped building, with an open court facing south. The easterly wing is the private pavilion, containing twenty-two rooms on a typical floor; on the west, is the ward wing with thirty-five beds to a floor. Connecting these two is the center section of the building which has a group of rooms with twenty-five beds assigned, theoretically, to semiprivate patients. Practically, the link is so elastic that in the event of a heavy influx of private patients, the semiprivate rooms adjoining the private wing can be readily converted into single rooms. If, on the other hand, the ward demand is excessive, the four-bed semiprivate units adjoining the ward wing can be used for charity patients. Similarly, there are rooms in the private pavilion that can be used for two patients if the semiprivate demand runs high. Thus, the semiprivate pavilion forms an expansion joint between wards and private quarters. There are no fixed lines or limitations.

Some will say that you cannot successfully put

	Beds	1923		Beds	1928	
		Number Hospitals	Percentages		Number Hospitals	Percentages
Private	1,685	..	10%	2,992	...	14%
Semiprivate	2,695	..	16%	3,272	...	15%
General Ward	12,469	..	74%	12,585	...	60%
Bassinets .....	..	..	....	2,274	...	11%
General Hospitals .....	..	63	....	....	71	....
Special Hospitals .....	..	41	....	....	45	....
TOTALS	16,850	104	100%	21,123	116	100%

a semiprivate patient on the ward side of the building or a private patient on the semiprivate side, but to argue against this is to argue not with facts but with a state of mind, because it has been done and it is being done successfully in many places. To give you an example. A hospital in New England recently added a new pavilion for private and semiprivate patients. Every room was convertible and designed to be used interchangeably for one or two patients. Each room has a lavatory, two built-in closet lockers and a recessed curtain locker, a new idea which has proved unusually successful. A fine, strong, inconspicuous aeroplane wire is stretched across the room, seven feet above the floor, into the locker, which is back to back with that of the adjoining room. An eyebolt going through both lockers replaces the usual clumsy turnbuckle as a means of keeping the wire always taut. The curtain hung on the wire is stored in the locker when it is not needed.

There are three floors. The lowest is allotted to semiprivate patients, all of the rooms being set up with two beds. The top floor is used for private patients, and on the middle floor, the unit of flexibility, the rooms are used as needed, single or double.

Simplifying the Problem

This hospital has a large courtesy staff and has adopted a rather interesting administrative policy, assigning the patients of the courtesy staff to the new wing and the patients of the attending staff to the old wing. This simplifies one of the problems incident to a large private and semiprivate service, where there may be almost as many doctors as there are patients. The new wing has been open three months. The first week the forty-four beds were filled to 50 per cent capacity, the second week to 75 per cent, and since then it has been running from 85 per cent to 90 per cent full. The superintendent tells me that he has had no class or social difficulties whatsoever in accommodating on the three floors of this building private patients, semiprivate patients who paid the full cost of their care, and patients who paid part of the regular charge, or nothing.

There is another hospital in a suburban town near New York which illustrates what can be accomplished when trustees realize that their institution is not adequately meeting community needs. This hospital has 120 beds. Sixty of these were in the wards, and had run for a number of years at from 40 per cent to 50 per cent occupancy. The ward patients were charity patients and were treated by the attending staff without charge. The community had a small

poverty problem. The need was for semiprivate, not ward, beds. The sixteen-bed wards were divided by cubicle partitions and the attending and courtesy staff were permitted to use the beds for their semiprivate patients. The new arrangement has been in effect for only three months, but the beds have been filled to over 90 per cent capacity. Whether this pace will hold throughout the year remains to be seen.

A New Jersey Example

A third example: In New Jersey in a city where the poverty problem is also negligible, a hospital had been operating for a number of years in an old building with fifty beds. A new and larger plant was built with approximately 75 per cent of its beds available for semiprivate patients. It has proved to be another illustration of what can be accomplished when the community is given what it wants and the administration is given a building designed to operate for good service at minimum cost. In the nine months of operation in the new building, drawing from the same clientele and served by the same professional staff, the daily patient census has increased from forty-one to eighty-six, or a total of 101 per cent. The per capita cost of operation was \$4.80 and collections from patients total 94 per cent of the total operating costs, or \$4.51 per day. The trustees of this institution experience no difficulty in collecting what is needed to fill the small gap between operating expenses and earnings.

These hospitals represent the new idea in planning. The large twenty-four- to thirty-bed wards of the past, each limited in its use to a definite service and sex, have been superseded by two-, four- or at the most eight-bed wards, which lend themselves readily to accommodating the varying loads of medical and surgical, male or female, free, part pay or semiprivate cases. They are demonstrating the new policies. The rates are reasonable. Patients are expected to pay them. It is "the thing to do," which is a far better psychology than the old, where constantly proffered charity undermined self-respect. None of these hospitals refuses a free patient, but they let him know that he is expected to pay when he can.

Exploiting the Patient

Of course there are always abuses, but the community hospital should aim not to permit either the public or the doctor to abuse the semiprivate privilege. Only last week I learned of a surgeon who was sending patients into a semiprivate ward where the rate was low, \$3 a day, and charging from \$200 to \$300 for an operation. The hospital was contributing unreasonably to his income.

Coming to my second question, what shall we charge the semiprivate patient? The average cost, according to the statistics of the United Hospital Fund of New York for twenty-seven general hospitals, is \$6.03 a day. Analyses of many hospital figures show that the receipts from extras, that is, the use of operating and delivery rooms, laboratory fees and x-ray charges average approximately 30 per cent of the amount collected for patients' board. That is, if we establish a semiprivate rate of \$4.50 a day for the bed, we may expect to collect from that patient an average of \$1.35 additional, or a total of \$5.85 a day. Even if our average cost is \$6, analysis of the figures of the comparatively few hospitals that have accurate cost accounting systems, indicates that with the proper proportion of overhead allocated to the semiprivate group, the figure of \$5.85 should fully cover the actual cost of his care. Many hospitals are charging more than this—\$5 to \$6 a day for board alone, but to the average semiprivate patient this rate works a hardship.

Empty Beds Are a Liability

My third point—how can we give the semiprivate patient the service he wants at the price he can afford to pay?—has already been partly answered. Obviously, from the financial standpoint the hospital materially benefits from the increased occupancy of beds that invariably follows the expansion of its semiprivate service. The twenty-seven general hospitals of the United Hospital Fund, with 78 per cent of their beds occupied during the year, show an average per capita cost for all patients of \$6.03, and an average of \$4.76 per day, collected from patients. Seventy-eight per cent occupancy means that of every 100 beds twenty-two are usually vacant. If it were possible, and it has been done, to convert some of the empty beds, which are most often found in the charity wards, to semiprivate use, and if ten of these were constantly occupied at \$5.85 a day, there would be an additional gross income accruing to the hospital of \$21,350 a year, a considerable sum.

What would each one of these additional beds cost the hospital if filled? On the pay roll, practically nothing. The floor supervisor is there, as are the floor maids, the orderlies, the administrative staff and the kitchen department. None of these would have to be augmented to take care of ten additional patients. The only extra cost for personnel would be for two or three pupil nurses. As to direct costs, there would be raw food sixty cents, laundry twenty cents, and incidental expenses, which might possibly bring the

total up to \$1.50 a day. Suppose we call it \$2, the extra expense would be \$7,300 for the ten additional patients, leaving a net return of \$14,000 a year. Many a 100-bed hospital has no larger deficit than this.

I have stated what three hospitals have done in the last few months to increase their semiprivate service and have shown how readily the new facilities have been taken advantage of. There is a hospital in New York City of 100 beds, planned primarily for the semiprivate group, which has adopted an unusual policy. Instead of trying to see how cheap a job it can do and cutting its expenses to the lowest point, the emphasis is constantly laid on improving the service. This hospital is planned to function without waste motion. It was arranged to provide the maximum of flexibility through interchangeable rooms, so that its medical, surgical and obstetrical patients could be readily kept segregated.

What is the result? It is always filled to capacity. During the past five years it has never averaged less than 94 per cent occupancy. It has charged no higher rates than any other hospitals of the city, yet it has always given substantially better food, more hours of nursing and, in general, exceptionally good service. Its per capita cost, around \$6.25 a day, is above the average. But the point about all this is that with 65 per cent of the patients paying less than cost and about 2 per cent wholly free, the institution has been able to wind up each year with practically no operating deficit.

This, it seems to me, largely answers the question. Our buildings must be planned to operate economically. They must be flexible. We must maintain a policy of service that will insure satisfaction to the patient and keep the beds constantly filled. If we will do this we can well afford to give the semiprivate patient the care he needs at a rate he can pay.

Movable Splint Cabinet Adds to Efficiency

At St. Joseph's Hospital, Victoria, B. C., it was found that the setting of fractures in the wards took much valuable time, and the nurses, not knowing exactly what the doctor's wants would be, made many unnecessary steps. This all caused delay, annoyance to the doctor and prolonged discomfort to the patient. The idea was conceived of using a movable splint cabinet. The cabinet is a complete unit, can be conveniently rolled into a private room or ward, and has proved satisfactory. It is divided into four parts, the upper being a deep tray for the Thomas leg splints. The lower forms a triple compartment in which are kept Buck's extensions, tools, twine, cord, bandages, adhesive, absorbent cotton, weights and an assortment of splints more commonly used in the hospital.

What Is in the Future for the Nurse?*

By FRANK E. CHAPMAN

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TO REVIEW "Nurses, Patients and Pocketbooks" is rather difficult without liberal quotation from the text and a reiteration of points made in the volume.

The report is prepared primarily for the benefit of the Committee on the Grading of Nursing Schools. It is designed as a fact-finding publication, and makes little, if any attempt to draw conclusions on the ground that with a knowledge of facts and the establishment of principles, a clearer understanding of the problems will obtain, and with this understanding will come a solution, in part at least, of the problems of the nursing profession.

The attitude of the committee is deserving of commendation in that they have been unwilling to make recommendations until fairly accurate data were compiled, establishing the relationship of supply to the demand of nurses and other basic information.

The tables presented, illustrating existing conditions and compiled from practically all available sources, seem to indicate the need of radical changes in education and employment. These tables and charts are presented in a comprehensive manner. The reading matter of the text impresses one with its extreme fairness and logical deduction. There is a wealth of material that certainly offers food for thought to all interested in the problem and

the committee's findings are clearly set forth.

Certain parts of the book present the relative growth of nurses in service, this ratio being established as between nurses and physicians, nurses and population and physicians and popula-

tion. The increase in the ratio of nurses is so startling as to compel an evaluation of new fields for the nurse, and the ability of these new avenues of service to absorb the increase. An attempt is made to estimate the probable number of nurses in active service each decade for the next thirty-five years, and the results obtained cannot but impress the student with the necessity of limiting the production of nurses, to the end that the health needs of the country may be served by properly trained persons, who in turn may be assured a sound economic status.

The study has further attempted to ascertain if the nurse today is meeting the need of the patient and of the doctor, and suggestions were solicited looking towards improvements.

Naturally, with the large number of questionnaires sent out different opinions were expressed, but from the physician there was a practically unanimous opinion that the doctor wanted a young woman with a good social, cultural and educational background, thoroughly trained and experienced in the care of patients. From the lay group, while there were adverse comments, in general, the impression is gained that the nurse is interpreted as an efficient, self-sacrificing indi-

Study the Nursing Market

HOW adequate is the supply of nurses?

Under what auspices do they work and what is the scope of the work done by each? The answers to these questions will be found in "Nurses, Patients and Pocketbooks," an authoritative book that no one who pretends to be informed on the nursing situation can afford to miss.

The report, which is based on an eighteen months' nation wide survey of economic conditions in nursing, has brought to light interesting facts regarding the alleged nursing shortage. It has, in fact, found the shortage to be nonexistent. On the contrary, the evidence points to overproduction of nurses, resulting in unemployment. Or is it perhaps a question of inadequate distribution?

The nurse is so closely related to community health that her status and welfare are matters of vital import to all. For this reason THE MODERN HOSPITAL throws open its columns to a discussion of the committee's findings as recorded in its first published report, and will welcome contributions to a symposium on the subject to appear in the November issue.

*A review of the first published report of progress of the Committee on the Grading of Nursing Schools, entitled "Nurses, Patients and Pocketbooks," by May Ayres Burgess, New York City. Price \$2.

vidual, although there are comments indicating need for adjustment of curricula and of established habits, especially by the hospitals in the training of student nurses.

One chapter in its entirety is devoted to the origin, social status and educational background of the nurse, and is full of pertinent information on the subject.

One of the most startling pieces of information and one of the most significant points brought out by the study is the educational status of the leaders in the field. The study shows a relatively low percentage of superintendents of nurses who have had any real preparation for their vocation beyond their hospital training course, and but little prenursing education to fit them especially for the teaching of young women. Equally significant is the lack of experience evidenced by the study of individuals charged with teaching. More than 77 per cent of the superintendents of nurses have not occupied their present position over five years.

The study calls attention to the motive behind many hospitals in conducting training schools, and rightfully emphasizes the need for changing the status of this type of training school.

The report is in no sense of the word intended as conclusive, but is well worth the earnest study of all interested in one of the vital problems of the health field.

Medical and Hospital Progress Go Hand in Hand

The rapid increase in the size and numbers and efficiency of hospitals in the United States within the last fifteen or twenty years has come about largely as the result of the amazing expansion of medical knowledge and the need of physicians for an adequately equipped workshop wherein they may serve the greatest number of patients.

This point particularly was stressed by Dr. N. P. Colwell, secretary of the council on medical education and hospitals of the American Medical Association, in an address on "What the American Medical Association Expects of the Teaching Hospital" delivered before the American Hospital Association at its annual meeting in San Francisco.

Briefly characterizing all modern standardized hospitals as "teaching" hospitals, Dr. Colwell, nevertheless, emphasized that the hospital connected with an undergraduate medical school in which all members of the staff were also members of the teaching faculty afforded the highest opportunities for instruction to medical students, nurses, interns, residents, staff members, local physicians and, through its extension service, physicians in remote outlying districts.

"Besides actual instruction," said Dr. Colwell, "the hospital wields a powerful influence for good in its locality through the information gained by its patients and ex-

tended by them to the public in the community, as well as by the hospital's visiting nurses and social service workers. From the observance of recent progress it appears that the possibilities whereby a hospital can wield its educational function have not been appreciated and are only at the beginning of their development. The more remote the district in which the hospital is the more important is this educational function since it has less competition or cooperation with other hospitals and therefore a more definite duty in the community.

"The hospital's educational function is a force working from within," continued Dr. Colwell. "Its development usually begins through the use of its immediate facilities for the further training of its own personnel. As hospital records show more careful examinations, better histories, more accurate and comprehensive autopsies and better conducted staff conferences, the educational benefits reacting on the hospital itself will gradually but assuredly be increased. To an increasing extent therefore the hospital is acting as a continuation school for the further development of practicing physicians themselves.

"In the examination and supervision of hospitals, therefore, it has never been necessary to establish a schedule of arbitrary rules. The American Medical Association has found it necessary only to note what the better hospitals are doing and present that as an ideal toward which other hospitals may strive."

Hospital Can Promote Educational Progress

The modern hospital in promoting investigation and in providing laboratories for such investigation is promoting educational progress which is leading to the discovery of talents hitherto unsuspected among hospital physicians, according to Dr. Colwell. Sometimes he said, excellent courses for graduate study are found in small hospitals where a physician or surgeon has demonstrated a remarkable teaching ability based on his own careful methods. Thus the hospital has among its educational possibilities that of becoming a normal school for the discovery or training of medical teachers.

The hospital library is often an indication of the institution's progress and reveals whether its staff members are keeping abreast of the latest medical development, Dr. Colwell pointed out. "But the real index of the hospital's progress and efficiency," he said, "is the percentage of deaths on which autopsies have been performed. This is not due to the mere fact that autopsies have been obtained but that the hospital is securing the highest educational value from them. This requires the keeping of careful records, the comparison of symptoms and physical observations with the actual causes of death as revealed by the autopsy, and the presentation of such facts in staff conference."

Dr. Colwell then summarized what he considered the essentials in a teaching hospital as follows: A staff and other personnel, not only competent professionally, but selected because of their high moral and professional standing; the board of directors, made up preferably of laymen who are prominent and influential in the community and who fully appreciate the high moral and professional tone needed in the hospital; the hospital plant, well constructed and well equipped, fire resistant, properly lighted, ventilated and maintained for the medical and surgical care of its patients with modern operating rooms, laboratories, private rooms and wards for patients. It should have also the essentials for educational advancement, such as record systems, autopsy room with refrigerating plant, library and pharmacy and similar facilities.

STUDIES ON HOSPITAL PROCEDURES

The Emergency Service

TO THE public the hospital is a place where modern scientific wonders are being daily worked. And in a measure this conception of the hospital's activities is fully justified. It is the belief of people generally that no matter how distressing the injury or how serious the disease, a cure is awaiting within the door of the community hospital, if only the patient can reach the institution in time. And this faith in the efficiency of modern medicine is often wisely placed.

On the other hand, those informed must confess that too often the life-saving efforts of the hospital and its staff are unavailing. Moreover, except in such emergencies as hemorrhage as a result of injury, or associated with pregnancy, and in a limited group of conditions where life is suddenly endangered, it cannot be gainsaid that a delay of a few minutes or even in many cases, an equal number of hours, is not likely to work serious detriment to the welfare of the patient. It is fortunate, however, that as a rule the confidence of the public in its community institution is such that the ailing man or woman is speedily given an opportunity of enjoying the benefits of the hospital's curative measures.

What Facilities Are Necessary

It is the purpose of this article to discuss in some detail the nature of the hospital's emergency work and to consider the facilities that the hospital should possess for meeting these requirements. No hospital can be considered complete today without a well organized and well conducted emergency service. The physical equipment and the personnel necessary to carry on this work may vary from a small room adjacent to the hospital's receiving ward, with nurses and doctors who are called from their ward work when needed, to a pretentious suite of rooms with full time nurses and doctors. Nor can this service be said to consist entirely of facilities within the walls of the hospital. A broader conception of the hospital's responsibility to the community for the prompt rendition of surgical or medical aid, must include the institution's responsibility

for the rapid transportation of patients from homes and places of employment to the hospital emergency ward.

According to the type of hospital, will be the volume and urgency of such needs. In an industrial community, it is easily understood that emergency surgery will constitute a greater proportion of the hospital's work than in an agricultural or residential district. Manufacturing concerns, railroads and coal mining companies in not a few localities have instituted their own emergency ward within or near their business plants. In instances where the number of workmen is large, there may be a full time industrial surgeon on duty. In such cases one often finds a number of beds where patients may be kept for longer or shorter periods.

Hospitals Cooperate With Industries

Not infrequently, however, in such communities the local hospital renders emergency aid to injured employees of plants near by, and serves not only a curative and preventive function, but also adds to the industrial prosperity of the locality by more quickly returning disabled laborers to their work. The type of services rendered in either of these instances usually consists of major or minor surgical treatment of crushes, lacerations and other types of injury received as a result of coming in contact with moving machinery, or of sustaining some disabling hurt peculiar to the industrial hazard present. In the general hospital the emergency department is often expected to care for patients who have come in contact with electricity, who are suffering as a result of the ingestion of solid or gaseous poisons or who have received bruises, crushes or fractures in the carrying on of their daily work.

An interesting development has taken place in the hospital field as a result of the modern forward surge in the use of the automobile and the aeroplane. Small institutions in towns through which new main highways have been built often find themselves taxed to the breaking point to care for those who have sustained injuries as a result of automobile accidents. In one instance, a small hospital that was being conducted by a private physician for the treatment of his own patients, was asked to care for so many injured automobilists, that a growing deficit required the community to assume the financial responsibility of carrying forward this work.

It is conceivable that the same service, if not in like degree, will be required of institutions on account of the increase in the use of the aeroplane for pleasure and for commercial purposes. In the neighborhood of certain large flying fields, there

are already developing small emergency hospitals, which often have been of great service. And there is also a preventive side to the work of the flying field hospital, because aviators and even passengers proposing to employ the air as a means of travel, are increasingly expected to demonstrate their physical fitness for such an undertaking before being allowed to leave the ground.

It has been intimated above that the emergency service of the general hospital consists of two functions—transportation of patients and their emergency care in the institution proper. The former often partakes somewhat of the function of the latter, because in cases of serious injury or even in those of a minor nature, the ambulance physician is expected to supply temporary or emergency treatment before undertaking the transfer of the patient to the hospital proper.

To the above divisions may be added a third, which consists in some cities of emergency receiving stations in various parts of the municipality. To such stations are brought accidents that occur on the street—fainting, apoplexies, heat exhaustion, as well as patients suddenly falling into labor. These divisions will now be considered separately.

How Station Is Administered

The emergency station is often administratively under the control of a local hospital. While this is usually a tax-supported hospital, such is not always the case. The nurses and interns on duty there are frequently delegated to these stations as part of their regular hospital service. These stations may be on a twenty-four hour schedule or they may be operated only during the day. The emergency station is frequently located in accordance with the greatest need therefor. Its equipment consists of such instruments and supplies as would be necessary to render first aid treatment to such conditions as have been named above.

Sometimes these outposts are a part of the organization of the department of safety in the community. Again, they may be partly financed by the town or municipality and partly by the hospital. Sometimes in addition to rendering emergency service, they are employed as admitting stations for the hospital proper. The justification for the expense of conducting such an activity in one or more localities in a town or city, varies with the location of the hospital, as well as with the type of community that it serves.

The administrative lines of authority must never be confused and the hospital's responsibility for the conduct of such work should be

clear-cut. Even though one or more agencies are supporting this work financially, there must be a definite fixing of administrative responsibility for its conduct. If the community hospital maintains these emergency outposts, there must be close cooperation between the record keeping of such stations and that of the hospital. This is particularly necessary because of the recent developments in our compensation laws. It is a common occurrence for industrial concerns as well as compensation companies to request detailed information concerning the nature, location and treatment of injuries received by employees during the course of their day's work.

Hospital Should Provide Ambulance Service

There is a considerable difference of opinion as to the hospital's responsibility for the maintenance of an ambulance service. In some localities it has been found satisfactory for the institution to rely entirely upon local cab and other transportation companies for the transfer of sick persons from their homes to the hospital. THE MODERN HOSPITAL has repeatedly expressed its opinion upon this subject. Concisely, it is believed that the responsibility of the community's hospital begins long before the patient is actually admitted to the institution. It is the duty of the hospital to make certain that the man who becomes ill in the home or the workshop, can be promptly transferred to the hospital.

As has been intimated, some industrial concerns conduct their own ambulance service. In some places, an ambulance may be promptly secured from a local concern at a reasonable figure. In others, it seems that the charge is exorbitant, and that it is the duty of the hospital to provide such transportation at or nearly at cost. Whatever system prevails, if any considerable delay takes place in making available the facilities of the hospital even to the most humble dweller in the community, it appears that the institution is neglecting a fine possibility for service.

Scheme for Cooperative Service Outlined

In at least one city, a number of hospitals are contemplating a cooperative effort that will include the purchase and maintenance of several ambulances so that each institution contributing may have promptly at its command such transportation facilities as it requires. It remains to be seen whether this scheme will prove to be as efficient as the tried plan of each institution possessing its own conveyance. Such an attempt may prove to be economically sound, since it cannot be denied that the ambulance of most hos-

pitals remains idle many hours during the day.

Too frequently repeated to be entirely without foundation, is the complaint that the hospital is often frantically called for aid, and the inquirer is told that the ambulance is busy and cannot therefore be sent for one or more hours. The public rightfully is not satisfied with such a condition. It has looked upon the hospital as an institution that is ready twenty-four hours of the day to render prompt service. The distress of mind of the relative who frantically begs the hospital's aid, only to be told that such a service cannot be rendered for what appears to him as an unendurable length of time, can be understood only by those who have experienced it. In instances where an institution, because of its size or its financial condition, is unable to provide an emergency transportation service, when its ambulance is not available, some other effective scheme should be evolved. This might consist of an arrangement with a local cab or bus company to provide ambulance service, at a nominal rate, when the need is great. An arrangement might be made with other near-by institutions so that emergency ambulance service could be provided on some mutually satisfactory basis.

Emergency Calls Demand Prompt Response

At times this failure to transfer patients to the hospital promptly can be traced not to the lack of ambulance facilities but to a poorly worked out system of receiving and answering calls for aid. The former function is often delegated to the telephone operator who is too frequently unable to render prompt attention to calls for ambulance service which she receives during the peak hours of her working day. There is a certain element of carelessness or routine in the transaction of this type of business. To the relatives who are frantically demanding aid an illness may appear as the direst emergency. To the sophisticated ambulance physician, it may appear as a condition to which the term "emergency" should not be applied.

Recently in a banking institution a department head was seized with what later appeared to be an epileptic attack. The occurrence of this illness threw those round about him into the greatest of confusion. A near-by hospital was importuned for help. No one at the institution could be reached by telephone who was apparently at all impressed with the seriousness of the situation. After the telephone call had been relayed from the telephone operator to the chief resident physician, to the secretary of the superintendent, and finally to the superintendent herself, the ambulance was promised. The bank president who

was telephoning, was greatly displeased with the service he received, and the hospital's reputation for rendering prompt and efficient service was not a little marred. Finally, when a somewhat officious and youthful ambulance physician arrived, and expressed his opinion that there had been much ado about nothing, those round about were to a greater degree tempted to condemn the hospital and its methods.

It is of not a little importance to the institution to have in its organization, some understanding, efficient and cool-headed person to whom emergency calls are referred. In institutions of size, this employee is sometimes designated as an "ambulance despatcher." His duties consist in efficiently directing the work of the institution's transportation department, in somewhat the same measure as a train despatcher handles, without loss of time, the movement of freight and passenger traffic for his company. It is of course necessary for such a person to know something of the psychology of those who are suddenly confronted with what to them is a threatening catastrophe. He must know the geography of his town, city or community so that ambulance mileage may be saved. He must have at his fingers' ends, a knowledge of how to locate the ambulance physician promptly, since time is frequently lost in securing a doctor to accompany the ambulance. The physicians assigned to this work are usually not allowed to leave the institution without permission, and as they move about in performing other than ambulance duties, they are required to keep the telephone operator in constant possession of knowledge concerning their whereabouts. When ambulance drivers are required to perform other duties, it is sometimes difficult to locate them promptly. Much attention should be given to formulating a system that will prevent the loss of time from any factors that tend to delay the departure of the hospital ambulance, particularly in cases of emergency.

Excessive Speed of Ambulance Condemned

As to the ambulance itself, this vehicle should provide the greatest possible comfort, speed and safety. Ambulance drivers generally seem to suffer with a common ailment, a symptom of which is an inordinate glee in creating an impression that the life of the community depends upon a speed which is neither safe for pedestrians nor for the occupants of the ambulance. This can be controlled by the installation of some type of automatic regulation, or by the use of a "recorder-graph" which will inform the superintendent of the exact speed at which his institution's ambulance has been driven at any time.

The emergency equipment of the ambulance should not be bulky, but should be inclusive enough to meet most emergencies that are likely to develop. The ambulance emergency kit should be inspected daily, possibly by the nurse in charge of the hospital accident ward so as to be certain that needed equipment and supplies are available at all times. A surgical kit with tourniquets, a sufficient number of instruments and ligatures, a carbon-dioxid-oxygen apparatus for the treatment of gas poisonings should be a part of this equipment. It lends a businesslike atmosphere to the ambulance if the chauffeur and the physician in charge are always in uniform. None but those actually required for ambulance work should be allowed to ride upon this vehicle.

Easy Access to Emergency Station Needed

The emergency station at the hospital should be so placed that prompt ingress and egress are always possible. Too often, because of lack of room, the entrance drive to the accident ward is only of sufficient width to admit one vehicle. In such instances an ambulance bearing a seriously injured patient may be prevented from reaching the accident ward door because of the presence there of a police patrol or some other vehicle. There should be sufficient room for turning, and if possible a porte-cochère or covered archway should provide shelter for patients when being removed from the ambulance or for relatives to alight.

There certainly should be no steps that must be traversed in order to reach the accident ward. This mistake in construction is so often made that mention should be made of the necessity for the provision of facilities to enable stretchers to travel from the accident ward to the ambulance entrance. It is not good practice to place the accident ward at a distance from the ambulance entrance. Emergency stations that are on other floors than the ground or first, may be promptly reached by elevator, provided this conveyance is always in working condition. If such an arrangement is necessary, however, emergency elevator service should be provided.

Entrance to the accident ward should be plainly marked so that, night or day, strangers may promptly find their way into this hospital division.

The arrangement and number of emergency station rooms depend largely upon the type and volume of work being done. It is a good scheme to set aside a room or rooms for emergency service only, and to carry on routine admissions in adjacent quarters. Patients being admitted to the hospital are thus spared the alarm that al-

ways results when they view a badly injured person being admitted to the hospital.

The proper assignment of personnel to the accident service is of great importance. From a teaching standpoint, this service supplies some of the most valuable experience that the young doctor and nurse can receive. The public expects the utmost promptness in the initiation of treatment when a patient reaches this division. It is to be regretted that so often nurses must frantically search the institution to find the physician assigned to the accident ward. Perhaps in smaller institutions where this physician has a multiplicity of duties other than those required in the accident room, some delay is unavoidable. Nevertheless, the impression that any postponement whether necessary or otherwise, makes upon the public, is not a favorable one.

While delays in the institution of treatment in the accident ward too frequently take place during the daytime, it must be said that at night this service is more likely to be slipshod. This is particularly true when the volume of work does not justify the presence of an intern in the accident ward during the whole night. Often the accident physician must be called from his bed, and the time that intervenes between this summons and his arrival, appears unendurable to anxious relatives, as well as to the patient himself. Whether it is a proper practice for the accident intern to be assigned a bedroom near the emergency ward, is debatable. Whatever arrangement exists, prompt service in the accident ward is rightfully expected by the community.

Equipment Needed in Emergency Ward

As to the equipment of the emergency ward, much can be said. It is not usually expected that major operations will be performed there. On the other hand, a complete supply of restoratives and antidotes for poisoning, some type of resuscitation apparatus, ample suture material and hemostats should certainly be on hand. It is a wise procedure for the hospital to have always present in the emergency room, a box in which are dressings, restoratives and bandages sufficient to render first aid to a large number of injured persons. No institution can be certain that it will not be called upon to treat, on a large scale, victims of some catastrophic occurrence such as a train wreck, a building collapse or a fire.

While the hospital may not always be able to meet the expectancy of the public insofar as its life-saving efforts are concerned, yet it should leave no stone unturned to prevent the loss of time in employing whatever remedies it has in its possession.

Editorials

The Nurse's Curriculum

FROM within the hospital's staff there comes with increasing frequency the complaint that nurses spend too much time in classrooms, listening to little understood, and to a still lesser degree assimilated lectures on chemistry, bacteriology and psychology, while the patients urgently need their presence in the wards.

The surgeon complains that he often finds the nurse uninformed as to even the commonplace events in the life of his patient since his last visit. To him afternoon class hours seem to be never ending. He longs for the presence of someone who will not reply to his question as to the duration of a nausea in his patient, that she doesn't know—she is only answering.

The physician wonders why he must endure what to him is an interminable wait in order to secure an intravenous tray. His irritation is not lessened by the knowledge that near by, in a classroom of the school for nurses, are a hundred pairs of hands busily taking notes on some subject which is, no doubt, interesting, but which, to the critical physician, does not appear essential to the nurse's armamentarium. To the staff physician it often seems that most of the nurse's time is consumed in classrooms attending lectures, or in laboratories, poring over microscopes.

How to care for the sick man adequately and at the same time properly educate the nurse is a problem neither new nor easy of solution. However all must agree that the former must be the dominant activity and the latter is a by-product.

But most nursing curricula do not require that a major portion of the student's time be spent in class work. In four of the largest hospitals in this country the weekly working hours of the pupil nurses vary from forty-six to fifty-seven. In one of these institutions, with a fifty-seven hour week, it was found that over a period of three years but 10.9 per cent of the nurse's time was spent in class work. This ratio was not maintained in each of the years of the nurse's course, varying from 42 per cent in the first to less than 10 per cent in the third year. Holidays, vacations and seasonal influences served to lower the total of classroom hours, but did not affect in the same degree the time spent in bedside nursing.

When the nurse executive is asked for a solution to this vexing problem she hazards the opinion that students in nursing should not be ad-

mitted to the hospital if they cannot be given ample time for study. The staff physician replies that the hospital should not assume the responsibility of admitting patients if they cannot be well nursed. Some would shorten the nursing curriculum, would train hands and would supply to heads only casual and scanty intellectual pabulum. Others would require night classes. Still others would send the probationary class to a central school for the teaching of preliminary subjects and would require no ward duties during the first months of the nurse's training.

In none of these proposals does THE MODERN HOSPITAL believe that the whole answer to the question is to be found. There must be at hand a large force of graduate nurses for supervisory and general duty ward work. When class time arrives and student nurses leave the ward, informed and willing graduates should remain to care for the sick and to satisfy the just demands of the visiting and resident physician. Night classes appear inhumane, and a radical abbreviation or reconstruction of the present curriculum without careful study would be short-sighted and probably ineffective.

To adopt reactionary methods in nursing education would lower the grade of applicants for entrance to our hospitals and would be a return to the intellectual and moral standards of half a century ago. The combined even though mute protests of the millions of sick men and women who would be wronged should nursing be harmed should cause us to proceed cautiously in applying any of the current remedies that are suggested for solving the problem.

A Survey of Hospital Fire Insurance Rates

READERS of this magazine have been urged through many years to safeguard patients and hospital property against fire. All phases of the subject from the planning and construction of buildings to the most improved methods for the storage of inflammable and explosive supplies have been repeatedly outlined. Likewise there have been full discussions of fire insurance and the means whereby rates may be reduced.

More recently there has been much discussion among hospital people on the subject of fire insurance rates. That hospitals are excellent risks from a moral standpoint is recognized, and that they have constant supervision, with nurses and others on duty during the twenty-four hours of the day, is a factor of protection and minimizes the fire hazard. The newer type hospital is, of

course, fire resistive and the rates are accordingly lower, but very often even in these institutions inflammable or explosive materials are stored under conditions that do not provide adequate protection.

Our investigations show that hazardous storage of x-ray films, faulty electric wiring, obstructed fire exits, inflammable waste materials and many other factors are responsible for the great number of fires and logically these are contributing causes in the building up of the final total that establishes the rate applied to an individual hospital.

Because of the importance of the subject in all its aspects and to develop adequate data on hospital fire insurance rates, THE MODERN HOSPITAL in conjunction with sixteen insurance rating bureaus is making a survey of hospitals in eighteen Middle Western states. From time to time the findings of these investigations will be published and it is hoped that as a result of this survey hazardous conditions will be remedied, thereby bringing about a reduction in the insurance rates on all hospital buildings and their contents.

In order to reap the full benefit of this study, hospitals are requested to give full cooperation to inspectors who may visit them for the purpose of ascertaining the exact and existing conditions of hospitals as fire risks. Administrators should take advantage of these visits and should ask these inspectors pertinent questions on what can be done to get a rate reduction. Inspectors will be especially instructed to aid in every possible way by making suggestions for the correction of defects and the lowering of the cost of fire insurance.

Why Should the Hospital Pay?

AUTOMOBILE accidents are about the best thing the American public does and invariably "the injured man was rushed" to the nearest hospital. His wounds are dressed; if need be, he is admitted for treatment; he recovers or dies; in any case, he leaves the hospital. Does he subsequently pay for his treatment? Nine times out of ten, he does not. It is the hospital that pays the bills for speeding and careless driving. Is this fair? It is not. The man who drives or owns a car is presumably not a proper candidate for charity. Common humanity demands that those suffering from "highway trauma" be treated, but it is not right that hospitals should bear this heavy burden and expend their funds, part of which, at least, are usually subscribed for charitable purposes only. Many

states are now considering laws which will require every automobile and airplane operator to carry accident insurance. Equity demands that this be done. Why should the hospital be penalized for the lawlessness and carelessness of irresponsible persons?

Scandal Commerce

SCANDAL is the parasite that battens on institution life. It shatters reputations, blights hopes and well-nigh crazes administrators. Innocent actions are distorted by it and peccadillos are magnified into deadly sins. It is malicious and uncharitable; it disturbs peace and foment trouble; it accomplishes no good and does much harm.

The scandalmonger is a moral buzzard who combs the garbage pile of human action for all that is decadent and offensive, the more odoriferous the better, only to thrust his findings into the consciousness of decent minds. Lazy, dishonest, imaginative, untruthful, he is ever ready to create distrust and to assail the motives of others. He fetches and carries, dropping the venom of his vicious tongue wherever he goes. Never constructive, always destructive, the scandalmonger has shaken solid institutions to their very foundations and has ruined the reputations of many worthy persons.

Scandal is without mercy and is absolutely ruthless in its attacks upon the innocent. A recent case illustrates this. An institution began to buzz with the gossip that the morals of a certain nurse were not above reproach; soon rumor had it that she was about to be confined; before long gossip fixed paternity on a young house surgeon. Further details were added, other reputations were attacked until before long, it appeared as though the whole hospital was a den of iniquity and vice. At last, the odorous miasma reached the superintendent who investigated the condition of his "State of Denmark." The nurse was found to have an abdominal tumor; it was disclosed that the house surgeon did not even know her. The nurse, a shy, modest girl, felt that she was forever disgraced and forsook her profession.

The only prophylactic against scandal commerce is banishment of the purveyor. The hospital that announces the basic policy that no scandal carrier will be allowed to retain connection with the institution and rigidly enforces it will rid itself of much trouble. As an adjuvant, there is nothing like keeping the force busy. Idleness produces many things, the worst of which is "scandal mongering."

Talking It Over

THIS month we celebrate the birth of Anthony Van Leeuwenhoek, whose natal day was the twenty-fourth in 1632. He it was who perfected the microscope first made by Hans and Zachariah Janseen in 1590, and he was the first of human kind to see a protozoön or a bacterium. The microscope really did not come into its own until the Pasteurian era. Once it was a curiosity; now, every child knows about it; man has increased his powers of vision many thousandfold. What a marvelous creature is man whose body we labor to preserve! He lengthens his stride and shortens distance; he strengthens his voice and casts it over the great deep; he grows wings and reaches the firmament; he transmutes the unruly waters into heat and light and power; he shapes the earth and its hidden wealth to his uses and wrests from Nature the secrets of her alchemy. He discovers the processes of life; he searches out the myriad of his infinitesimally small enemies and destroys them; he lengthens the span of his existence that he may garner new truths and make fresh conquests. How wonderful is the brain and spirit with which this being has been endowed.

* * *

THRIFTINESS is something at which every institution should aim. In the hospital field we are indoctrinated with this idea in the days of our apprenticeship and we depart not therefrom when snow bedecks our temples and time has furrowed our faces. Yet many of us never get beyond the preliminary stage of being thrifty. We learn that the institution dollar must be conserved, yet never grasp the vast possibilities of thrift in a big way.

* * *

REALLY worthwhile thrift saves the little things. Day by day these little savings pile up and multiply until eventually their total is enormous. Thus economy becomes a routine procedure and produces a frame of mind in which every reaction is antagonistic to waste. The thrift habit has been created. The organization functions at an optimum of efficiency and new entrants thereto automatically become thrifty.

* * *

WE HAVE too many off-key and off-time players in the hospital field. The success of a hospital is absolutely dependent upon the performance of the team as a whole. One discordant note reverberates to every corridor and corner of the institution, disturbing patients and personnel alike, and what should be a haven of peace becomes a den of bickerings and backbitings. If every person, from the board of trustees to the most humble employee, is not well synchronized, rhythm will be destroyed and the patient will not receive the quality of treatment that is his due.

* * *

RETROSPECTION is frequently most heartening, and when the oldsters retrospect and tell the youngsters, much good is done. Give this picture to the operating room gang and watch the results:

An indifferently lighted chamber with a narrow deal table, a few hard stools, one or two small tables, a hand basin and a cake of soap. The patient in cotton nightgown is stretched on the bare table, the anesthetist, whose face is covered with sparse youthful wisps, rolls up his sleeves, unbuttons his collar and claps a cone over the victim's face. Two collarless male nurses wander about

the room. Enter the surgeon. One male nurse assists in removing his Prince Albert coat and hanging it on a peg behind the door. The surgeon dons a much pus and blood besplattered P. A. coat, unbuttons his sleeves and rolls them back, washes his hands with soap and water, tucks his flowing beard in his vest, fumbles around in an old leather bag and gets out a canvas roll containing instruments. Another nurse opens it and spreads it on a table. The surgeon runs his fingers through his hair; the anesthetist says, "He's asleep;" the surgeon selects a knife from the canvas roll and goes to work. Myoma of the thigh requires blunt dissection; the surgeon holds the scalpel with his teeth and dissects with his fingers. Sutures wound with silk; sticks in drain saturated with "blue pus" (pyocyanus) to ensure "laudable pus;" one male nurse bandages the thigh; the patient is returned to the ward.

* * *

OR, TRY this reel: Operating room equipment about the same; operation site has been scrubbed, shaved and put up in a weak carbolic solution the night before; the surgeon and assistant scrub up in a 1 per cent carbolic solution; antiseptic cleanliness is beginning to take the place of social cleanliness; the instruments are sterilized (?) with 5 per cent carbolic, in which they lie for thirty minutes before the operation; if a forceps is dropped on the floor, it is dabbled in the sacred carbolic solution and immediately put back in service. Once the patient is asleep, a few sea sponges, magically cleansed by carbolic immersion, are laid out and the carbolic spray turned on. Enveloped in an aromatic fog, the work begins. Everywhere and dominating all surgical thought was carbolic acid; it "magiced" away the demons of infection; it saturated operator and patient alike; small wonder that surgical teams had smoky urine. Catgut soaked in carbolized oil had supplanted silk; healing by primary intention was now definitely sought; surgeons were beginning to get the idea that manual cleanliness was more important before than after operation. Ether and chloroform were the only anesthetics used.

* * *

ANOTHER picture in the surgical album: White gowns have come in; there is less carbolic and more permanganate and oxalic acid for manual ablutions; instruments are boiled; attempts at sterile catgut, silk-worm and horsehair (will anybody forget the horsehair skin sutures) are being made. The operation sites are scrubbed, shaved, laved in bichlorid and alcohol and then poulticed with soft soap. Antisepsis is passing; men are talking about an aseptic conscience; more attention is being paid to the construction and outfitting of operating rooms. Sterilizers appear and primary union is more common; the abdomen is invaded with greater optimism; surgery is venturing further from the shore. Then Halstead's rubber gloves come into being, replacing the thick, clumsy gauntlets hitherto used only at necropsies on dangerous communicable diseases; the days of bare knuckle surgery are gone; caps and masks are used and modern surgery has arrived.

* * *

THESE pictures all exist in the memories of living men, thus demonstrating the almost unbelievable advances of the surgeon's art. We smile covertly at the crudities of those days now happily bygone. They appear almost as a joke but the real joke lies in the covert smiles our successors will have over us and our methods.

The Modern Hospital Reading Course: Lesson XXII

Care for Chronics, Convalescents and the Preventorium Child

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THIS chapter of the reading course will deal with the care of the chronic patient, the convalescent patient and the preventorium child.

It is perhaps natural that the great majority of the hospitals of the country have developed their facilities principally with the idea of caring for the acutely sick. The person who becomes suddenly and dangerously ill undoubtedly draws the attention and sympathy of the public to a greater extent than one whose ailments are of a less arresting nature. The acutely ill patients undoubtedly should receive first consideration. Money spent for their care is a good investment in that it may save their lives or may prevent more lasting illnesses.

Hospitals therefore have largely confined their attention to the acutely sick for these reasons. They have also been influenced against the care of the chronic patient in particular because of the system of training of nurses and interns now in effect.

The chronic patient whose condition is but little changed from day to day is considered poor material for the practical instruction of nurses. The convalescent is also shunned because the nurse is probably learning but little in caring for him. The intern enters the hospital for a year of intensive training in the care of the sick, and he wishes to get as concentrated a dose of all types and varieties of cases as possible. He naturally prefers the hospital where the turnover is rapid and where he sees a large number of patients for a short time rather than a smaller number for a longer time.

Hospitals have also had difficulty in keeping pace with the demands made upon them for bed

space. They have accordingly been forced to ask the chronic patient to seek care elsewhere and to discharge many of their patients before their convalescence is complete.

As a result of all these combined factors, the chronic patient in the past has been left largely to shift for himself. If he had ample means he could usually secure private care. If he were destitute or became so because of his expensive illness, he was usually lodged in an almshouse or

similar institution. The convalescent patient was left largely to his own devices for the period intervening between his discharge from the hospital and the time when he was able to resume his occupation. In many instances the occupation has been resumed too soon and the patient has suffered accordingly. There can be no doubt but that lack of properly supervised convalescence has often

made the end result of the patient's illness unsatisfactory when, with proper care, it would have been otherwise.

Even though the patient with a chronic, disabling disease may be able to secure for himself quarters where he will obtain ordinary food and care and even good nursing attention, he is often neglected medically. In the hospital where there are also acute cases, a distinct tendency exists among the physicians to spend their time upon the more interesting and exciting acute conditions, leaving to secondary consideration and sometimes to neglect the chronic patient. This tendency is likely to obtain with interns and other young graduates. It is believed that while an intern should not spend a great portion of his service in caring for chronic diseases, he can learn a great many things from these patients.

Review Work

1. Take a city with whose hospitals you are familiar and evolve a plan for adequate institutional facilities for convalescent patients.
2. Draw a floor plan of a building or buildings suitable for a 100-bed preventorium.
3. Why are almshouses undesirable for the care of the chronically ill?
4. Outline bed capacities of all needed public hospital services for a county of 250,000 population.

They more nearly approximate the types of cases he will see in general practice than do the cases of acute appendices and pneumonias.

It is probably safe to say, therefore, that the care of the chronic patient in a general hospital is not entirely satisfactory, even if beds are provided, unless especial pains are taken to see that the chronic cases are studied as thoroughly and visited as often as the others. It is true that many chronic cases are but little improved by any treatment. It is strikingly true, however, that in certain cases careful medical work will do wonders. The care of the chronically sick in the ordinary almshouse is often inadequate. Almshouses usually maintain what are called infirmaries in which the patients are cared for according to varying physical standards. A visiting physician usually looks after emergencies and doles out pills. More than likely there is neither laboratory nor x-ray equipment. There may be an operating room for emergencies although that is less desirable than might appear because the handling of surgical cases in such an environment is not conducive to good results.

Many public hospitals, particularly county hospitals, have developed from almshouse infirmaries, an ancestry that has, to say the least, embarrassed their development.¹ It is generally agreed by persons in a position to know that the average almshouse standard and the average almshouse executive are not adequate to the development of proper hospital facilities. The development of a hospital for chronic diseases, therefore, in the ordinary almshouse is not a solution of the problem. In some states the existing laws prevent even these almshouse infirmaries from accepting patients who are not already paupers, according to the almshouse standard. For this reason many needy but self-respecting chronic patients can seek no help from such institutions. How, then, can the chronic patient best be provided for? A large proportion of the chronically sick are also indigent, or so nearly so that they cannot finance their own care. A considerable number, however, are able to pay a reasonable amount for their care and a few are able to pay for expensive accommodations.

More Beds for Chronics Needed

The problem then is not entirely confined to the public hospital. There are a very few outstanding private institutions for chronic diseases. There is no doubt a need for the development of more such institutions or for the development of chronic sections attached to private general hospitals. The Montefiore Hospital, New York, has been a pioneer in the chronic hospital field and

its officials have contributed much of value to the literature on this subject.^{3, 4}

In the New York area the great need now is for more beds for chronic patients who can pay a moderate price.² A hospital of this type operated at a per capita of \$5 a day could be promptly filled with persons able at least to pay cost. The development of such private institutions appears to be urgent. In a few communities good provision is made for the care of the indigent chronic, while the chronic patient who can afford to pay has no place to go. It would be well for hospital councils or other organizations representing private hospitals to consider this question in the light of the needs of their particular communities, and to urge the establishment of hospitals for the chronic patient or departments for his care in general hospitals. Every superintendent of a general hospital for the acutely ill will testify to the fact that in busy times of the year he has had to demand the removal of chronic patients without being able to advise their families of any other institution able to give the necessary care.

Burden Falls on Public

In most large centers of population an attempt, at least, has been made to develop hospital facilities for chronic cases. Such patients are so likely to have spent their last dollar in an attempt to secure treatment that they have become charges upon the public. Visits to these hospitals are often depressing and discouraging to the observer. In few instances should they be dignified with the name of hospital. They are invariably overcrowded with scores or hundreds of incapacitated persons, all thoroughly discouraged as to the outcome of their illness under the care of poorly trained attendants who themselves, through lack of funds and lack of knowledge, have become discouraged. They are so overworked and so lacking in funds to give proper care to the patient that they have lost whatever vision or hopefulness they may originally have had. There has been little adequate training for either physicians or nurses in the care of chronic cases, and personnel that have been trained in the hospital for the acutely ill are too likely to consider the chronic case hopeless from the outset. Many of the institutions for chronics, therefore, have become almost purely custodial. An attempt is made to keep the patients comfortable, to feed them as well as funds will permit, and to show them as much kindness as the thirty or forty dollar a month attendant is able to give. In short, the public hospitals for chronics are far below the average of hospitals generally.⁵

In Alameda County, California, a plan that is

well worth the study of public welfare officials has been developed. That county has no almshouse as such. Early in the development of the Alameda County plan it was found that practically every adult who became a charge upon the public had become indigent because of some disability, physical or mental. The almshouse, therefore, was abolished and in its place a hospital for chronic diseases was created. This was a great strategic advantage to the chronic patient because, instead of caring for the chronic patient according to almshouse standards, the institution is organized as a hospital and follows hospital standards. An excellent medical service has been developed with interns from the large county hospital for the acutely ill rotating also through the hospital for the chronically ill. The patient who elsewhere would be considered an ordinary almshouse inmate also derives an advantage because he is looked upon not as a poor person but as a person who is incapacitated and in need of treatment. In conjunction with the medical care given, an excellent system of occupational and vocational therapy and training has been worked out. The chronic patient if he cannot be cured may often be made self-sustaining by the adjustment of his occupation.⁶

The Department of Public Welfare of Westchester County, New York, is attempting to develop along similar lines. For architectural reasons, only a few of the chronic patients may be cared for in the general hospital, and the infirmary in the county almshouse takes the less serious cases. This infirmary, however, is under the medical supervision of the county general hospital as is also the medical care of all other persons in the almshouse. Free transferring of sick persons from the almshouse to the general hospital is practiced and the almshouse inmates in their medical care are not subject to the ordinary almshouse standard.

Hospital for Chronics Planned

For the future it is planned to develop a large hospital for chronic diseases which will take all chronic cases now in the general hospital as well as all patients now in the almshouse infirmary. This hospital will be operated as a department of the general hospital for the acutely ill, the patients having advantage of all of the facilities of a large medical center.

There are some arguments in favor of locating hospitals for chronic cases in rural areas where there is plenty of light, air, and open space. This should not be done, however, if the location will make the institution difficult of access to physicians of the community who will be needed to

staff it. If the hospital is under public auspices, its proximity to the general hospital is most desirable and should be arranged unless there is a certainty of adequate medical service at some other location.

Buildings should of course be fire resistant and should provide everything for the comfort as well as for the medical care of the patients. Day room and sun porch space should be adequate. The presence of many wheel chair and crutch cases should be taken for granted and the building designed for their convenience. There seems to be no objection to multi-storied buildings provided there is good elevator service and facilities for getting patients out of doors readily in good weather.

Facilities Needed for Chronics

Extensive occupational and vocational facilities should be provided and, of course, laboratory and x-ray facilities must be of the best. The physiotherapy department should include all types of apparatus and needs to be large. Hydrotherapy is valuable in these cases. Every facility should encourage medical work. The hospital for the chronic patient should plan to transfer its operative surgery to the hospital for the acutely ill, although there should be equipment for minor and emergency work of this nature.

Hospital authorities should not lose sight of the fact that there is a genuine human appeal in the needs of the chronic patient. The public in general does not yet realize the amount of suffering among this class of patients nor does it realize, except in isolated instances, that the splendid community hospitals which it supports are doing little to solve the chronic patient's problem.

Appeals for funds for this work may be made effective whether they are made to governmental appropriating authorities or to the individual subscriber through a public appeal. In certain communities beds for acute cases are more than adequate. If the hospitals in these communities wish to render still greater service to the public they should not lose sight of the golden opportunity to do the right thing for the chronic patient.

As an introduction we can do no better than quote in part from the opening paragraphs of an excellent volume recently published by the Sturgis Fund of the Burke Foundation, White Plains, N. Y., entitled "Convalescence, Historical and Practical," by John Bryant, M.D.:

"The general subject of convalescence occupies a rather unique position. On the one hand, the early recognition of the importance of this

transition stage between sickness and health is witnessed by the writings of Hippocrates and his successors, and appreciation of the necessity for giving organized consideration to the period of convalescence had already reached such a stage that in Paris both the Hôtel-Dieu and the Charité Hospital, in 1640 and 1650, made special provision for the care of convalescent patients. On the other hand, . . . there were available in 1920 . . . a total of only ninety-two articles listed under the general title of 'Convalescence.'

"This absence of any extensive literature seems accurately to mirror the chronic apathy of the medical profession with regard to serious interest in the subject of convalescence. . . .

"The total result of this lack of interest is that with the exception of a few shining examples . . . the care of convalescent patients has for the most part been left to drift by itself without intensive medical supervision; in consequence, this is almost the only branch of medicine which has made minimal progress in the last fifty years or more."

Patients Are Discharged Too Soon

All who are familiar with the care of the sick realize that many patients must be discharged from busy hospitals before they are in a condition to work. In such hospitals as can keep the patient longer there are seldom proper facilities for a real convalescence; also the expense of giving convalescent care is higher than is necessary for the convalescent. Moreover, few hospitals are situated in environments that are desirable for convalescence. In fact, a study of hospital convalescents in their homes made incidental to the Cleveland Hospital and Health Survey, indicated that only 12½ per cent of discharged patients returned to homes that were entirely satisfactory for their convalescence. Six per cent of the discharged patients were found to be still in need of further hospital care, having relapsed or having been discharged too soon, and 81½ per cent were found to need either adjustment of home matters or care in some other place to effect proper convalescence.^{7a} Dr. Frederic Brush suggests that a city discharging 100,000 hospital patients annually should provide institutional care for at least 12,000 convalescent patients.

The most notable development in the care of convalescents in America is the Burke Foundation, a private, endowed institution, at White Plains, N. Y. St. Luke's Hospital, New York, has recently opened a million dollar convalescent home near Greenwich, Conn. New York City has more facilities for convalescent care than

any other in this country.⁸ The other larger centers, however, are slowly awakening to this need. Convalescent homes are preferably situated in rural or semirural areas at not too great a distance from the city from which patients are drawn. The larger convalescent homes have usually found it convenient to establish offices in the city they serve, at which places applicants for admission are interviewed. From these points comfortable transportation is provided to the home which may be from five to thirty miles distant. In accordance with the purposes for which the convalescent home is organized, it forms connections with hospitals and other sources of patients requiring convalescent care, and arranges with these sources for needed co-operation as to the type of patient as well as to the stage of convalescence at which he may be accepted.

The social service department of the convalescent home works closely with those of the referring agencies with the understanding that patients sent by the hospitals to the convalescent home are, in case of relapse, to be readmitted immediately.

Considerable acreage is required if the needed health giving diversions and occupations are to be provided. The buildings must be made as attractive and as complete as possible. Ample space must be provided for indoor as well as outdoor recreation, for occupational therapy, games and social contact generally.

Hospital Has Golf Course

The convalescent home should have sidewalks or dry paths to permit graduated outdoor exercise. Dr. Frederic Brush of the Burke Foundation has made an important feature of golf as an exercise for convalescents. That institution not only has a regulation golf course, but has developed small and less difficult courses that permit the assignment of this recreation in graduated form to the patients.

Occupational therapy is usually an important feature and practically all of the convalescent homes assign to patients who are able, light tasks in connection with the daily work of the home. Some provide monetary compensation.

The dietary is an important part of the care and must be carefully managed.

Nurses and nurses' aids in sufficient number are employed in the general supervision and care of the patients.

The average stay at the Burke Foundation in 1920 and 1921 was nineteen days for women and twenty days for men, with the exception of cardiac cases. These remained twenty-six days.^{7b}

The three general types of convalescents that must be considered are cardiac cases, children and others.

Special attention is required for the first two, and if children are accepted in a convalescent home they should be sufficiently segregated to prevent their disturbing the older patients and to keep them from contact with adults.

Students of hospital administration are urged to visit and study representative convalescent homes to gain a clear understanding of their function and of those problems with which the hospital can assist.

Preventive Work Is Important

The children's preventorium has developed mainly in connection with the nationwide crusade against tuberculosis. The preventorium, as its name implies, is intended to prevent illness. It, therefore, receives patients who are not definitely sick but who are in danger of breaking down. Most of these institutions receive the majority of their cases from among children who have had intimate contact with positive cases of tuberculosis but who upon physical examination reveal no active tuberculosis. If the child does have active tuberculosis he is naturally taken to a hospital for the tuberculous. These contact children, while susceptible to tuberculosis, are also susceptible to the proper type of preventive care and often show astounding improvement.

The preventorium provides adequate food, rest, work and play. It should be, and usually is, a happy place where the child has every opportunity to thrive.⁸ The length of stay is ordinarily three months or more and the child is not sent back to his home until he is well past the danger of illness and undesirable home conditions have been corrected.

These preventoriums are often located near tuberculosis sanatoriums,⁸ although in some instances they are not connected with any other institution. They are preferably situated in the country. The outdoor facilities must be equal to those in the convalescent home and especially adapted for children. Heliotherapy is considered an important part of the treatment, and in many preventoriums the children wear very little clothing the year around, in this respect being treated according to the plan of Rollier of Leysin.

One advantage of connection between the preventorium and a general hospital is that splendid facilities are found in the hospital for the correction of defects that may endanger health. Every preventorium should plan to look after diseased tonsils, to put the teeth in good condition and to immunize the child against the var-

ious diseases for which there are immunizing agents.

Preventoriums need not be confined to the care of children exposed to tuberculosis. Any child who is under weight, whose health habits need correction, or whose diet needs study and supervision not provided by the home is likely to be benefited by preventorium care.

Schools are almost invariably conducted in preventoriums. They assist in keeping the child occupied and the teachers have a golden opportunity for teaching health and hygiene at an impressionable age.⁹

The ordinary preventorium usually accepts children whose ages range from four years to twelve or thirteen years. Younger or older children are likely to interfere with the routine. Where the need exists, however, separate provision should be made to care for such children.

The worker who is familiar only with the general hospital and who thinks of hospitals in connection with the problems of the institution for the acutely ill patient is lacking in a sufficiently broad conception of the care of the sick. The convalescent, the chronic, the underweight child and the mental case are all a part of the picture. A study of the ideals and the needs of such institutions will give the hospital administrator a greatly enhanced view of the possibilities for community service.

Bibliography

1. A.H.A. 1927 Proceedings, pp. 234-235.
2. Lewinski-Corwin, E. H., *Hospital Situation in Greater New York*, pp. 305-310, N. Y. Putnam, 1924.
3. Bons, E. P., *Mod. Hosp.*, 26: 138-141, Feb. 1926, Chronic Diseases, a Challenge to the Hospital and the Community.
4. *Mod. Hosp.*, 26: 312-314, Apr. 1926, Place of Chronic and Convalescent Hospitals in the Care of the Sick.
5. *Nation's Health*, 8: 597-599, 654, Sept. 1926, Paupers Need Hospital Rather Than Domiciliary Care.
6. Goodfriend, J., *Med. Jour. and Rec.*, 123: 616-618, May 5, 1926, Montefiore Hospital for Chronic Diseases.
7. *Hosp. Man.*, 21: 63, Jan. 1926, How Hospitalization Has Helped Chronic Patients.
8. Bachmeyer, A. C., *Mod. Hosp.*, 25: 338-339, Oct. 1925, What the Survey Shows About Hospital Conditions in Cincinnati.
9. Jensen, A. C., *Mod. Hosp.*, 26: 305-307, Apr. 1926, Where Chronic Patients Are Receiving Special Consideration.
7. Bryant, John, *Convalescence*, 269 pp., pub. by Burke Foundation, N. Y.
- 7a. Pp. 94-95.
- 7b. P. 65.
8. Brush, Frederic, *Hosp. Soc. Serv.*, 3: 391-394, May 1921.
9. Douglas, Bruce H., *Mod. Hosp.*, Vol. 26, No. 4, Apr. 1926, Detroit's Interesting Method for Preventing Tuberculosis.
- Mod. Hosp.*, Vol. 28, No. 6, pp. 73-79, Del Valle Farm and Its Children of the Sunlight.

Jefferson County T. B. Hospital Expands

New buildings and additions to the existing building are being planned at the Jefferson County Tuberculosis Hospital, Beaumont, Texas, and will include the extension of the central building for white patients, a new service building, kitchens, dining rooms, nurses' home and an infirmary for negro patients. Steinman and Son, Beaumont, Texas, are the architects and T. B. Kidner, New York City, is consultant.

YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. **THE MODERN HOSPITAL** will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

What Fire Hazards Are Peculiar to Nurses' Homes?

In any building housing a large number of persons, there is found much thoughtless disregard for the safety of others. The homes for nurses in the hospitals of this country house many thousands of young women who are careless, and who are living in an age which is inclined to act first and think afterwards.

The advent of smoking among young women has added an extra fire hazard. This is particularly true because often it must be done clandestinely, and the sound of the approach of supervisory footsteps usually brings about a quick discarding of the forbidden cigarette. If a waste basket happens to be handy, it is likely to receive the cigarette, an act of carelessness that may result in a subsequent fire. Curling irons carelessly left attached with the current turned on, have been known to start a fire by igniting wooden bureaus or shelves. The practice of permitting ironing to be done in nurses' rooms has often resulted disastrously in the same manner. Chafing dishes, toasters and other electric cooking equipment have sometimes resulted in destructive conflagrations. Exposed and defective electric wiring is sometimes at fault.

The remedies for the above hazards lie in education as well as in the installation in the minds of all of a responsibility for the safety of others. A special laundry in the basement, in which all ironing by nurses must be done; strict enforcement of the prohibition of smoking in the nurses' rooms; talks on the steps to be taken should a fire develop, are worth while suggestions for minimizing fire hazards. It should not be necessary to add that buildings used for the housing of patients or of the hospital personnel, should not be, in any part, used as a place for the storage of inflammable materials, such as paint, varnishes, drugs or chemicals.

How Can the Hospital Promptly Secure Blood for Transfusion?

In hospitals with large medical services, or in those doing accident work upon a considerable scale, the question of promptly securing a blood donor is often troublesome.

The profession of blood giving has come into existence as the practice of transfusion has increased in popularity. Indeed, in some large cities, there are not a few persons who have come to know the type of their own blood, and who have registered their willingness to sell

blood, at one or more hospitals. These persons are always required to present serological evidence of their freedom from disease. Sometimes, particularly in the case of ward patients where money is not at hand to purchase blood at the current price, it can be secured as a by-product of therapeutic bloodletting in cases of hypertension and other similar conditions. It is a simple problem to Wassermannize such persons, and this transfer of blood, "profits both him that gives and him that takes." In cases of polycythemia in the donor (excess of red blood cells), it is the opinion of some physicians that less blood needs to be given than when the donor possesses a normal red cell count.

Often the best method of securing blood is to appeal to the relatives, friends, fellow lodge members or fellow employees of the patient. It is not usually difficult to obtain blood for a soldier, policeman or fireman, if the need is made known to others performing the same work. Unfortunately, it is sometimes difficult to obtain the proper type of blood on short notice, and for this reason it is often best, when the need for a transfusion is anticipated, to begin searching for a possible donor before the blood is actually required. However, the process of typing blood is so simple that this procedure need delay the operation hardly at all.

In some institutions, a fund is set aside for the purchase of blood at the current price of \$25 to \$50 for 500 c.c. The social service department is often useful in quickly finding a blood donor when the need for a transfusion is urgent.

How Can Proper Ventilation of Hospital Diet Kitchens Be Secured?

The question was asked by a hospital in the western part of the United States. In this institution, the main kitchen is forty feet long and fourteen feet wide. The hood covering the ranges does not include the steam kettles that are placed near by. A duct, six by twelve inches, leads from the main kitchen to a ventilator on the roof of the hospital. There is a circular opening ten inches in diameter near the ceiling of the kitchen, leading into this duct. The diet kitchens are in the same location on each floor, and have small ducts leading to the space between the top slab and the roof above it. The superintendent complains that the kitchen so arranged is faultily ventilated, and asks **THE MODERN HOSPITAL** to express an opinion thereon.

It has been found by kitchen experts that range hoods should be fairly deep, and that the slope of their roofs should not be too gentle. Sometimes, these hoods are connected with a ventilating duct on the side. This is not good practice.

Sometimes, ventilation is secured through a grill near the top of the hood leading into a built-in flue, which conveys smoke and gases to the roof of the hospital and to the outside air. Again, the hood may be ventilated

with a direct flue from its top, leading to outside air above or into a built-in flue.

It is not found to be efficient for the duct ventilating the hood to have too many angles in its course. In this instance, it seems that there should be a direct communication between the hood over the stove and the opening of the duct which is in the ceiling of the room, eleven feet from the hood. If this duct could be placed at a rather sharp angle not less than forty-five degrees, better ventilation would be secured. An exhaust fan placed in the main ventilating duct, would certainly produce a better draft. The main ventilating duct leading to the roof of the hospital should emerge a sufficient distance so that a draft would be produced by the outside air blowing across its top.

It is to be remembered that the principle of a modified water vacuum pump is operative in thus producing the suction of foul air, smoke and gases from below. Insofar as the ventilation of the diet kitchens on the various floors of this hospital is concerned, it seems wiser to have a main duct at least a foot square, into which each diet kitchen could be ventilated. It is not felt that in this situation, there would be any danger of a back draft contaminating the diet kitchen on other floors. Direct hooding of kitchen equipment without trusting to ventilation through a grill set in the wall, is a sound practice. The heating of the air in a ventilating flue by means of a small gas flame or of a smaller steam jet, has aided in producing a prompt upward flow of contaminated air.

Should the Hospital's Supply of Liquors Be Used for Other Than Medicinal Purposes?

It seems that a knowledge of federal and state enactments relative to the conditions under which the hospital secures whisky and other alcohols for medicinal purposes, would quickly bring a negative answer to this question. On the other hand, a somewhat perplexed and distressed superintendent has requested THE MODERN HOSPITAL to express an opinion regarding this matter.

In this institution it has been customary for a number of years for the regular monthly meeting of the board of trustees to be followed by a dinner supplied by the hospital. At this function members of the board have grown to expect that an alcoholic drink will be served. The ingredients for this beverage before prohibitive measures were enacted in regard to the consumption of alcohol, had been supplied by the hospital. A newly appointed superintendent has found herself in a situation of reviving this practice or of possibly offending these board members. She is reluctant to do either, yet she shrinks from breaking both a state and federal law at any cost.

Unfortunately this situation has existed at times in some form and degree in more than one institution. In another hospital of which the writer has knowledge, inspectors from a state welfare department had come to expect that upon their visits to the hospital some alcoholic drink would be forthcoming.

Now, while in the above situation the new superintendent finds herself in an embarrassing position, there appears to be but one course to follow. If there is a particularly understanding member on this board to whom the situation could be tactfully explained by the superintendent, it would be wise, perhaps, first to seek his advice as to the best course to pursue.

The diversion of alcohol to any other purpose than that with a purely therapeutic basis, is certainly a breach of faith with the authorities who permit the hospital to secure this drug at a cheaper price, and in larger quantities

than is allowed to individuals. And certainly it is true that the hospital should be outstanding in its respect for the law.

Persons must be subordinated to principles, and in this particular instance it seems that after a tactful but fruitless recitation of the facts to a board that should be understanding, a flat refusal to serve alcoholic drinks seems to be the only course open. THE MODERN HOSPITAL is glad to publish this opinion in the hope that it may be of service in solving a troublesome problem in the hospital particularly affected, as well as in any other locations in which this question or a similar one has presented itself.

Should the Nurse's Record Be Filed With the Patient's Chart?

THE MODERN HOSPITAL has expressed an opinion on this subject on a previous occasion. It is the practice in some institutions for the nurse's record to be kept upon a chart board separate from that upon which the history, treatment and laboratory sheets are to be found. Indeed, some institutions do not feel that it is necessary for the rather bulky nurses' records to be permanently filed with the remainder of the chart.

Some executives, however, feel that the value of the nurse's record is not of such a doubtful nature that it should be thus discarded. The mere fact that a physician writes an order upon the patient's chart, does not in any way prove that the drug was administered at the time it was ordered to be given. A clear statement by the nurse that she saw and understood the order, and that it was properly executed on time, is a clinching proof that the patient received this treatment. Moreover, in compensation and other cases when it may be necessary to prove that the patient received just and adequate treatment, the nurse's record may be of inestimable value.

It is true that considerable material is to be found on these sheets which, after the patient has been discharged, is of little moment, as far as the scientific record of the case is concerned. Nevertheless, it is also not to be disputed that on these sheets are to be found personal comments as to the reaction of the patient to hospital life, to his treatment and to his environment in general, which are of not a little social and scientific value.

But above all other arguments for the permanent filing of nurses' records, it seems that the verification of the fact that treatments that were ordered were promptly and correctly given, stands out prominently. Moreover, any question that might be raised by those not kindly disposed to the hospital as to the consummation of any therapeutic measure, would be discredited by the testimony of an additional person—the nurse—that the proper treatment was given.

How May Nonboilable Sutures Be Kept Sterile Without the Use of Alcohol?

This question has been asked THE MODERN HOSPITAL by a midwestern institution. In some hospitals, all suture material, whether boilable or nonboilable, is sterilized without the use of alcohol. To this end, nonboilable tubes are placed in a sterile container and covered for one hour with formalin of 2 per cent strength. It is felt in these hospitals that the tubes thus treated, are safe for placement upon the sterile surgical table. In most of these institutions, bacteriological studies have confirmed this belief.

For night operations, a fresh solution of formalin of

the same strength is used, the same container being employed as during the day. A sterile piece of gauze is placed on top of the tubes in order to keep them submerged in the formalin. On the outside of the container is placed a piece of adhesive which is marked with the date and the hour when its contents are ready for use.

Should the Superintendent Recommend Any Specific Hospital Products?

Almost every hospital executive is importuned from time to time to permit his name to be used as a recommender of articles that he has found to be useful and trustworthy in his work. Sometimes he is rather inclined to state his belief concerning the value and fair price of hospital articles that have particularly appealed to him.

However, it can be said that for the administrator to permit his name to be used as part of an advertising propaganda for any sort of merchandise or instruments is in the long run most unwise. He may be fully convinced in his own mind as to the particular value of such products, but should his name appear as a sponsor for patented articles it lays him open to suspicion that he is profiting financially thereby.

It is another matter when colleagues address personal inquiries to him in regard to the merits of any such articles. It is certainly proper, when importuned by firms for the use of his name, to state that he will be glad to answer any inquiries from other hospitals concerning their products. These opinions can be in the nature of a confidential communication and will not endanger the good name of the writer.

How Can Measles in the Children's Hospital Be Controlled?

It is a well known fact that measles has a biennial or triennial tendency to be present in epidemic form in large centers of population. The statistics of hospitals receiving contagious diseases bear out this statement.

In hospitals for children there is no more troublesome contagious disease than measles, unless it be chickenpox. Hospital beds are rendered useless to a community over long periods of time by the presence of this disease. So easily transferred is measles, that the presence of one case in a children's ward, is often responsible for the isolation of many patients over long periods of time.

There are many steps that may be taken to curb the spread of this disease, more or less successfully. In some institutions a well conducted observation department in which all patients are detained for a period of two weeks before entering the hospital proper, has proved efficacious. Of course in such a department isolation facilities for each child must be at hand. If, after a period of two weeks, no contagion develops, it is most likely that the child was not incubating such a condition upon admission.

On the other hand, in institutions that allow visitors to children, particularly in the presence of an epidemic outside of the hospital, it is almost impossible to prevent the development of this disease in the hospital. It seems wise and just to all concerned, when measles is present in epidemic form in the neighborhood, rigidly to restrict visiting in the children's department. With the modern system of aseptic technique in nursing, unless there is a break in the chain, the occurrence of one case of measles in a cubicle ward should not endanger other children.

But even with the strictness of precautions, this theoretic safety does not always work out in practice. The intramuscular administration of thirty to sixty c.c. of

whole immune blood, has, in the minds of not a few observers, mitigated or entirely prevented the development of measles in those who were rather intensively exposed. This procedure is apparently practically harmless and is often productive of good results.

The division into small groups physically separated from each other, of a large group of children who have been exposed to measles, has been found useful. It is sometimes possible for nonimmune children to be thus prevented from contracting measles, if they have been fortunate enough to be placed in a group in which no secondary case develops. Intensity of exposure is a factor which, in the minds of not a few, has some bearing. Children who have a definite history of having had measles, may be admitted to an exposed ward with safety to themselves. It is to be understood, however, that there are some instances in which a primary attack of measles seems to have been succeeded after a longer or shorter period with a secondary attack, but this is a rare occurrence.

Vacating of infected wards, careful inspection twice daily for Koplik's spots or other evidence of a developing contagion, exposure to sunlight and fresh air, all are practical measures that are useful in controlling the spread of this disease.

Who Shall Fix Laboratory and X-Ray Rates?

This question was asked by the superintendent of a hospital in the southern part of the United States. She appended to this question the query as to whether the clinician or the laboratory director should draw up the schedule for these charges.

It can be truthfully said that neither the clinician nor the laboratory director should fix these charges, acting separately. The superintendent of the hospital with the director of the x-ray or clinical laboratory should gather together as much data as possible relative to the schedule of charges in effect in neighboring institutions comparable to their own. When this material has been collected, and after suitable alterations have been made consonant with the economic status of the local clientele, and the quality of service performed, the schedule of charges should be submitted to the governing body of the staff for its consideration and approval. Such rate cards frequently contain a minimum and maximum charge for each specific service. In other words, the charges made to a private room patient are often greater than those made to ward patients for similar types of work.

After the governing body of the staff has had time to consider these charges the rate card should be forwarded to the board of trustees for its approval. The board of trustees, having placed its stamp of approval upon the charges to be made, the rates then become effective and must be observed by the respective laboratories affected.

No matter if the head of the x-ray department is paid on a percentage basis he should not be permitted to alter at will the rates charged for his work. Should he be permitted to do this, criticism might be brought upon the hospital.

Sometimes the compilation of a scale of charges is left entirely to the superintendent, and while perhaps he is able to perform this task more speedily and just as efficiently, it would seem wise that both the director of the laboratory and the staff should be at least consulted before it becomes effective. Inspection of x-ray and laboratory charges allowed by compensation companies may serve a useful purpose when it comes to fixing institutional laboratory and x-ray rates.

NEWS OF THE MONTH

California Dietitians Find Inspiration in Meeting With A. H. A.*

THE council meeting on Monday afternoon, August 6, opened the annual session of the California State Dietetic Association which met jointly with the American Hospital Association in San Francisco, August 6 to 10. Alvina Misch, president of the association, presided. What new material was to be included in the compilation of diets, and the adjustment of dues to the American Dietetic Association to leave a working budget for state work were among the important matters discussed. Reports showed a total of 133 active members on the roster.

The Tuesday morning open forum of the American Hospital Association with Helen B. Anderson, Scripps Metabolic Clinic, La Jolla, Calif., presiding, opened up a lively discussion on questions of importance to the dietary department. The comparison to the army traveling on its stomach made a fine working basis for constructive thinking. Do we in our hospitals give as good a ration to our workers as the army? Do we keep the protein and caloric levels of dining room dietaries sufficiently high? Do we have adequate supervision of food service? Do we have high ideals for food service? Does the allotted cost of food per day allow adequate nutrition from the standpoint of bulk as well as of calories? Is it to the interest of the hospital to limit dietary below the level of nutritional needs? Can we set a dietary standard? How many hospitals have health examinations for kitchen employees? What are our standards of food quality? Of food quantity? Do we ever check on edible food waste as well as on unavoidable food waste? What is the professional standing of the dietitian? Where should the dietitian's office be placed? What are the advantages of cafeteria service where nonprofessional help pay for food? Why do hospital dietitians leave the field for commercial work? What is the responsibility of the hospital to the student dietitian? Is it worth while to work out raw food costs for dietary departments? What is the advantage of dumb-waiter service over cart service? How many hospitals are working out food costs? What is the relative cost of metabolic diets? These and many other questions were discussed with vigor at the open forum meeting.

The Tuesday afternoon meeting of the California State Dietetic Association proved interesting to the large group attending. Alvina Misch, University of California, San Francisco, gave the address of welcome and Dr. L. H. Burlingham, Barnes Hospital, St. Louis, Mo., president-elect of the American Hospital Association, spoke convincingly of the place the dietitian holds in the hos-

pital group. Effie Raitt, University of Washington, Seattle, Wash., gave a comprehensive paper on "The Internship of the Dietitian." She stressed the need for a broad educational background before such internship is entered upon. She then outlined the points that need emphasis in the student courses as now given in hospitals. The first point driven home was that we must stress the importance of the patients having confidence in the doctor. Secondly we must, she said, give the student ample opportunity to apply theory of nutrition to the practical problems of hospital dietary. Also the student should know what she can reasonably expect the personnel of the dietary department to accomplish in eight hours' time. She should get the point of view of the worker. Hospital etiquette, hospital ethics and traditions and the relationship to other groups should be explained.

Many Dietitians Leave Hospital Field

Dr. Agnes Fay Morgan, University of California, Berkeley, gave an interesting discussion and extension of Miss Raitt's paper. Dr. Morgan called attention to the fact that the best students from training courses do not always stay in hospital work. She feels that hospital superintendents should consider this carefully. The fact that many women with the rare quality of leadership necessary for administrative work are leaving the field because of lack of cooperation between hospital superintendents and dietitians, is a grave consideration.

Work done in the Kahler Corporation, Rochester, Minn., on the diet in sprue was reviewed in brief in a paper read by Mrs. Helen A. Douglas. Etiology, symptomatology and treatment other than diet were considered. The high protein diet modified by low per cent vegetables proved the most favored dietary regime.

The afternoon meeting adjourned to hear a talk on "Interdepartmental Problems of Diet," given by S. Margaret Gillam, University Hospital, Ann Arbor, Mich.

On Wednesday morning the annual business meeting was held. The officers elected were: Alvina Misch, University of California Hospital, president; Susie Scott, San Jose Hospital, vice-president; Martha Davis, University of California, second vice-president; Marguerite Molfino, Sisters' Hospital, Sacramento, secretary; Elizabeth Fogg, California Lutheran Hospital, Los Angeles, treasurer.

On Wednesday afternoon Mary A. Foley, Kahler Corporation, Rochester, Minn., read a paper by Dr. Clifford Barborka on ketogenic diet in epilepsy, discussing etiology, symptoms and problems of treatment. A simple method of diet calculation was outlined, theoretical ratios shown and diets worked out in detail listed. Case reports showed some of the problems of carrying out the

*Reported by Helen B. Anderson, Scripps Metabolic Clinic, La Jolla, Calif.

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diet as far as education of the patient and careful figuring and weighing of the diet are concerned. The necessity of teaching patients urine analysis was also stressed. Difficulties that present themselves are the education of the patient, the infringement on diet rules, the sense of hunger due to lack of bulk and the expense of the high fat diet. Dr. Pulford of the Woodland Clinic gave an interesting discussion of this paper.

Following this a paper on diet during radium therapy caused much interesting comment. The use of alkaline ash diets showed good clinical results.

Several dietitians told of their work. Ann Boller, Chicago, spoke of the diet work in Rush Medical Clinic, Chicago, telling of the out-patient work done with diabetics, epileptics and gastro-intestinal cases. She stressed the fact that individual teaching seemed the only satisfactory method. Lulu G. Graves, New York, consultant in diet therapy, presented the problem of the consultant dietitian emphasizing the need for long and varied experience and many contacts and definite affiliations before attempting consultant work. Miss Graves felt that for the average dietitian the hospital offers more than any other field. She pointed out that people trained in dietetics have a splendid opportunity and that there never was a time when dietotherapy had such unlimited possibilities.

Diet Kitchen Training Outlined

Thursday morning brought the culminating event in the dietetic meetings. The dietetic session of the American Dietetic Association was splendidly attended and rightly so. Bertha Beecher, Christ Hospital, Cincinnati, presided and introduced first Mary A. Foley, who gave the report of the food and equipment committee. This year a study of diet kitchen training of the student nurse was made. This was especially timely since a standard outline has not been worked out for this part of student nurses' training. Two hundred and fifty questionnaires sent out brought response from 215 hospitals. Dietitians felt that the length of the diet kitchen course should be six weeks. Superintendents of nurses felt that special work should be given to nurses who wished to elect the subject of dietetics. In fifty hospitals no definite outline for diet kitchen procedure had been used. The chief drawback to definite courses has so far been that dietitians do not know when nurses are to come into and leave the diet kitchen. Great improvement in nurses' interest can be gained by more contact between nurses and patients and more case study, it was emphasized.

Helen Anderson, dietitian, the Scripps Metabolic Clinic, La Jolla, Calif., opened the discussion of this paper and suggested that nurses could not be given training in dietetics in the short period allotted, and also that the question of giving an adequate enough understanding of the problems involved to insure cooperation between nurses and dietitians should be the ideal. Elective work in dietetics should be allowed to nurses wishing to do diabetic or nephritic nursing or to those wishing to do administrative work in the large group of hospitals having fifty beds or less and having no dietitian. When the problem of including certain types of diets is advanced we are immediately faced with the situation that many hospitals have few metabolic diet cases and therefore

diets, such as diabetic, ketogenic and saltfree can be given only in the abstract. This point was stressed in the interesting discussion that followed.

This report was followed by a paper by Margaret Spiers, Berkeley Health Center, Berkeley, Calif., on the social service dietitian. She outlined the problems met and the necessity for the dietitian's understanding case work well enough to correlate problems of diet with other social problems.

Luther Reynolds, superintendent, Methodist Hospital, Los Angeles, Calif., spoke upon the place of the administrative dietitian in the hospital group. He stressed the fact that the dietitian must work in close communication with the doctor whose diet prescription she fills. He felt that much of the routine of the hospital dietary department should be placed on other shoulders.

The last paper on this very interesting program was a discussion of diet in arthritis by Dr. E. F. F. Copp, resident physician, Scripps Metabolic Clinic, La Jolla, Calif. After discussing the classification of arthritis Dr. Copp pointed out the fact that only two types of arthritis are amenable to diet treatment, namely, hypertrophic osteo-arthritis and atrophic osteo-arthritis. He showed type diets demonstrating that diets as low in calcium as 0.020 grams can be given with calories as high as 2,000. Diets high in calcium were also shown. So far this work on diet in arthritis is unpublished and though results have been gratifying the work has not been extensive enough to be conclusive.

The exhibits were an educational feature of the annual meeting.

Approximately sixty dietitians registered for the meeting and all agreed that the fourth annual meeting in conjunction with the American Hospital Association was in itself an inspiration. The stimulating effect of an interchange of ideas and ideals will bring about a closer cooperation between administrative groups this coming year, it is expected.

Directors of Nurse Training Schools Take Advantage of Summer Course

De Paul University, Chicago, offered a summer course of instruction in principles of teaching, psychology, hygiene and administration of nursing schools to all directors of nurse training schools, which started at the opening of the 1928 session. The course of instruction, which was conducted by competent and thorough instructors, was said to be especially good. It is expected that this course will eventually develop into a well established department of nursing.

The course was originally planned for the Daughters of Charity of St. Vincent de Paul of the Western Province of the United States. Their superiors, realizing the need of keeping in touch with every step in the progress of nursing education, sponsored the introduction of this course and arranged for all engaged in the capacity of directors to take advantage of it.

The realization has come that such schools have a double function, first, to train young women to make proper adjustments in life, and second, to train them to

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become efficient nurses. In order to educate effectively the nurses it is first essential that the instructors should be well trained in both the subject and the best method of teaching the subject.

The matriculation represented Sisters from many parts of the country, namely, Alabama, California, Indiana, Illinois, Louisiana, Missouri, Tennessee, Texas, and Wisconsin.

Public Health Meeting Arouses International Interest

Prominent hospital officials and authorities will lead in the discussion sessions of the fifty-seventh annual convention of the American Public Health Association, which will be held October 15 to 19, inclusive, in Chicago at the Stevens Hotel.

The convention will be divided into eleven main sections as follows: epidemiology, cancer, industrial hygiene, public health officers, public health nursing, foods, drugs and nutrition, child hygiene, public health education, public health engineering, vital statistics and a laboratory section.

This year the association meets jointly with the American Child Health Association and the American Social Hygiene Association. The first joint session on Monday evening, October 15, will be the opening meeting of the convention, at which Dr. Herman N. Bundesen, president of the American Public Health Association, will deliver an address of welcome. A second joint session will be held Wednesday evening when Dr. Frank G. Boudreau, who represents the health division of the League of Nations, will be present to speak on "International Health." Dr. Boudreau comes direct from Geneva, Switzerland, especially for this meeting.

Sections that will probably be of great interest to hospital workers are those on child hygiene, vital statistics, and health officers, as well as the sections on the laboratory and on public health engineering.

In the laboratory section Dr. Benjamin Kline, Samuel Littman and M. C. Bowman, all from Mount Sinai Hospital, Cleveland, will present the results of their twenty-five hundred microscopic slide precipitation tests and Wassermann tests, with clinical comparison.

Varied Topics to Be Discussed

Dr. Fred L. Adair, professor of obstetrics and gynecology, University of Minnesota Medical School, Minneapolis, Minn., will preside over the child hygiene section. Maternal and infant mortality, obstetrics, gynecology and abdominal surgery will be discussed at the various sessions of this section.

The symposium for health officers will be under the direction of Dr. C.-E. A. Winslow, Yale University. One of the outstanding papers of this section will be presented by Dr. Dennett L. Richardson, City Hospital, Providence, R. I. Dr. Richardson's subject will be "The Care of Communicable Diseases in General Hospitals." Dr. W. S. Rankin, Duke Endowment, Charlotte, N. C., will lead the discussion following Dr. Richardson's paper, and Dr. George T. Palmer, director, division of research, American Child Health Association, New York, will close the

third session of this division with a report on the recent activities of the organization that he will represent at the meeting.

In the vital statistics section Dr. Benjamin Goldberg, secretary, board of directors, Chicago Municipal Tuberculosis Sanitarium, Chicago, will speak on "Tuberculosis in Racial Types, With Special Reference to Mexicans." Robert Bruce Watson, Newark, N. J., will present his recent research in a paper on "The Relation of Climate to Tuberculosis."

All sections of the convention will be open to any delegates or visitors attending the meetings, and probably the one that will arouse the greatest general interest will be the section on epidemiology, which will be led by Dr. Edward S. Godfrey, Jr., director, bureau of communicable diseases, New York State Department of Health. In this symposium Dr. Haven Emerson, department of health administration, Columbia University, New York, will speak on "Ratio Distribution and the Death Rate of Diphtheria in New York City." Dr. Lloyd Arnold, professor of bacteriology and preventive medicine, Loyola University, Chicago, will lead a discussion on "Waterborne Epidemics in Diarrhea."

The public health engineering section will be divided into two main discussions: "Sterilization of Milk Containers and Equipment," and "Shellfish Sanitation." In the latter symposium George W. Fuller, consulting engineer, New York, will present a paper and lead the general discussion.

Many Inspection Trips Planned

Inspection trips of interest to workers in every field of health have been scheduled to Chicago institutions offering the most interesting observations in their particular fields. Eleven scheduled trips and sixty-three optional ones are on the program. Three trips of special interest to hospital workers have been planned. The first one includes the new children's building at the Cook County Hospital, the Illinois Research Hospital of the University of Illinois Medical School, and the Municipal Contagious Disease Hospital. The second scheduled trip will start with the Daily News Sanitarium for Children and Mothers. From there the Children's Memorial Hospital will be visited, and the trip will terminate with an inspection tour through the Chicago Municipal Tuberculosis Sanitarium.

The third trip will offer observations of two of the country's most interesting medical, surgical and dental clinics—those of the University of Chicago Medical School and the Northwestern University Medical School. Laboratory workers will find the trip through the new Albert Merriitt Billings Pathological Laboratory an interesting one, as well as the trips through the research laboratories of the Durand Hospital and the Municipal Tuberculosis Institute.

Among the 3000 delegates and visitors who have already signified their intention of being present at the convention will be hospital superintendents from some of the oldest institutions in Europe. The fact that large groups will be here from Germany, England, Sweden, Canada, Mexico and the Canal Zone shows clearly the regard in which the progress of health work in this country is being held internationally.

Among the Associations

Practical Topics to Be Discussed at A. C. of S. Meeting

THE program and arrangements are now complete for the eleventh annual hospital standardization conference of the American College of Surgeons, to be held in Boston, October 8 to 12. A glance at the program shows that numerous practical suggestions are to be discussed. Monday, October 8, the first day of the conference, will be devoted to the presentation of leading suggestions by outstanding speakers. These will deal with such subjects as health inventories in approved hospitals; the interest and influence of the Duke Endowment in hospital standardization; "Nurses, Patients and Pocketbooks;" missed pedagogic opportunities incident to the usual organization of the resident medical staff of the hospital; medical education and specialization; experimental science *versus* imitative art in medicine; the role of the hospital administrator; visual methods in conducting the staff conference.

Dr. Munger to Conduct Clinic on Records

The Tuesday morning session will deal in great part with the economic and scientific aspects of out-patient and social service work and the operation of a physical therapy department, with leaders in the respective fields taking part. The Tuesday afternoon session will be a clinic on case records conducted by Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., in which all the ills of case records will be thoroughly discussed by people prominent in this work. The record librarians or historians from all over the United States and Canada will meet in Boston at the same time and will hold several interesting sessions. They will join with the American College of Surgeons on Tuesday afternoon and participate in the program.

Great interest centers around the Wednesday morning open forum on problems involved in the professional care of the patient, to be directed by Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn. The following important subjects will be considered: measuring the professional efficiency of the hospital; standard of surgical efficiency; medical staff organization; relation of the clinical pathologist to the medical staff and the scientific work of the hospital; responsibility of hospital trustees for the professional care of the patient; follow-up; appraisal of nursing service; the clinico-pathological conference as an educational factor in the hospital.

On Wednesday afternoon two sessions will be conducted simultaneously, one, the hospital session of the eye, ear, nose and throat section, at which will be discussed vital problems relative to the care of these special cases in general hospitals. Leaders in this special field and hospital administrators will participate. The other session on Wednesday afternoon of unusual interest will be the open forum directed by Paul Fesler, superintendent, University Hospitals, Minneapolis, Minn. The small hospital of twenty-five to 100 beds, so essential in many

communities, finds it imperative to comply with the hospital standardization requirements of the American College of Surgeons, and frequently encounters many problems in its endeavor to do so. This program has been planned to present a practical solution for all these problems and will include such topics as the following: What the Duke Endowment is doing for the small hospital; how the large hospital can assist the small hospital in complying with the requirements; how the medical staff of the small hospital can be organized and function so as to meet the requirements; how the small hospital can maintain a record system acceptable to the American College of Surgeons; how the small hospital can build up the essential special services to a degree acceptable for approval, particularly the clinical laboratory and the x-ray department.

The conference will conclude with the Thursday morning session which will take up such important subjects as the care of obstetrical patients in general hospitals; the care of the convalescent patient; the responsibility of the hospital administration in the care of fractures; the responsibility of the hospital administration in the care of the injured; the possibility of postoperative infections from contamination of water in hospitals; beauty in the hospital.

A hearty response has been received to the invitations sent to hospital trustees, superintendents, doctors, nurses and others to attend this meeting and everything points to the most interesting program in the history of the American College of Surgeons.

American Dietetic Association to Meet in Washington

The eleventh annual meeting of the American Dietetic Association will be held at the Hotel Willard, Washington, D. C., on October 29, 30 and 31.

Plans are well under way for an interesting program. Among the speakers will be people well known in the various fields of nutrition and the allied professions. The tentative program is now ready and will be mailed on request.

Sight-seeing and professional trips are being planned in Washington and Baltimore for the Thursday after the convention, and for those who arrive the Sunday before there will be trips in Washington.

The usual commercial exhibit will be held in connection with the convention and will contain some exhibits of especial educational value. An electrically equipped special diet kitchen for a 100-bed hospital will be one of the features. The noncommercial exhibit, which has had considerable material added to it this year, should prove a most worthwhile one to visit.

News of the Month

Iowa University to Be Dedicated in November

The completion of the new General Hospital of the University of Iowa, Iowa City, Ia., constitutes an event of the utmost significance in the life of the university and of the whole state. The work of construction has practically been completed and the beginning of the 1928-1929 session will witness the opening of the building which is the chief unit of the new west side medical campus. With the opening of the hospital the entire medical school will be moved to the west side of the Iowa River. Preliminary announcement is now made of the dedication ceremonies which will be held on November 15, 16 and 17.

The new medical campus is situated on the bluffs on the west side of the Iowa River, overlooking the Old Capitol campus. It consists approximately of eighty acres. The Children's Hospital was built on this section of the campus in 1919, and an addition to this unit was built in 1925. To the west of the Children's Hospital is the Psychopathic Hospital and the new Westlawn Nurses' Home.

To the south of these buildings are the new medical laboratories building and the new General Hospital. The former houses all the preclinical departments of the medical school and the medical library. These departments have all been operating in the new building during the past year. The new hospital building is of the same architectural design as the laboratories building, and is of brick with limestone finish. The building is approximately 300 by 500 feet in size and is set back from the highway, leaving a fine approach and adequate grounds to emphasize the building's splendid proportions.

Central Tower Is a Landmark

The central tower has been finely conceived and is architecturally of great beauty. Rising 143 feet above the street level it dominates the entire west campus and is already a landmark for the city. The building will have accommodations for about 750 patients.

There are sixteen large wards for twenty patients each, the remainder of the beds being in small wards and single or double rooms. The out-patient department will occupy the first and second floors of the east wing, while the third and fourth floors will be devoted to classrooms and to laboratories for teaching and research activities. The west wing will provide isolation facilities on the first floor, private rooms on the second and third floors, and will house the department of obstetrics and gynecology on the fourth floor.

In the center sections are the administrative offices on the first floor, wards on the second, third, fourth and fifth floors and operating rooms on the sixth and seventh floors. Quarters for interns are on the third, fourth and fifth floors. The building has unique features, both in construction and appointment.

The realization of the plans for the new building was made possible by the donation of over \$4,000,000, part of which was appropriated by the Iowa State Legislature, part by the General Education Board, and part by the Rockefeller Foundation.

The work of transferring the 400 patients and all of the supplies and equipment from the old to the new building will start about October 10. Robert E. Neff, administrator of the university hospitals, and his assistants, are making careful plans for the necessary transfer so that the patients may be moved with a minimum of discomfort. The process of moving, it is believed, will take at least ten days.

In order to lessen the difficulties of the transfer, the hospital authorities plan to lower the number of patients in the hospitals as much as possible in the days before the move begins, by postponing the admittance of all except emergency cases until they can be cared for in the new building.

Delaware State Hospital Plans Twenty-Year Building Program

The board of managers of the Delaware State Hospital, Farnhurst, Del., has approved a twenty-year building program for additions to this institution. Among the new buildings projected will be one unique in state mental hospitals, namely, an observation clinic located quite apart from the main group of buildings in which patients will be received for observation without being formally committed under the usual procedure of admission.

It is intended that this observation clinic shall fulfill the functions of a psychopathic ward in a first-class, modern general hospital. Experience with such wards has shown that many persons suffering from temporary mental illness make a complete recovery after a short period of treatment and are able to return to their homes without the stigma of having been committed to a hospital for the insane.

In addition to the observation clinic, the initial installment of the twenty-year building program will probably include two sixty-bed continued treatment units, one for each sex; an eighty-bed reeducation building for male patients; a new nurses' home and the remodeling of several existing buildings. R. P. Schoenijahn, Wilmington, Del., is consulting engineer and T. B. Kidner, New York City, consultant.

New Editions of Sanatorium and Association Directories Ready

The eighth edition of the Tuberculosis Sanatorium Directory is ready for distribution. It contains detailed information regarding tuberculosis sanatoriums, hospitals, day camps, preventoriums and other tuberculosis institutions. These are listed geographically and include the date of establishment, bed capacity, character of patients received, rates charged, method of application, name of medical director and, wherever necessary, information as to the easiest way to reach the institution.

The new edition of the Tuberculosis Association Directory is also ready. It contains a list of 1,454 organizations, state and local, in addition to special committees that assist in the sale of Christmas seals and other phases of the yearly program.

Personals

DR. ANDREW H. WOODS has been appointed director of the State Psychopathic Hospital, Iowa City, Ia., to succeed Dr. SAMUEL T. ORTON. Dr. Woods will also serve as professor of psychiatry at the University of Iowa medical school.

DR. E. L. BUSBY has been appointed superintendent of the Western State Hospital, Hopkinsville, Ky., to succeed W. M. ELLIOTT who recently resigned.

GRACE L. MCKELVEY has recently been appointed superintendent of the Yonkers Homeopathic and Maternity Hospital, Yonkers, N. Y., to succeed BESSIE A. BUDD.

DR. JOHN N. THOMAS, after serving for nearly twenty years as superintendent of the Central Louisiana State Hospital, Pineville, La., tendered his resignation and has been succeeded by DR. CLARENCE PIERSON.

DR. G. M. G. STAFFORD has resigned as superintendent of the State Colony Training School, Alexandria, La. DR. R. C. TOMPKINS has accepted the appointment as his successor.

DR. ARTHUR VIDRINE has recently been appointed superintendent of the Charity Hospital, New Orleans, La., succeeding DR. WILLIAM W. LEAKE.

DR. ARNOLD S. ANDERSON, formerly medical superintendent of the Buena Vista Sanatorium, Wabasha, Minn., has resigned to accept a public health position in St. Paul, and has been succeeded by DR. RUSSELL H. FROST.

DR. GORDON E. STRATE is the newly appointed assistant superintendent of the Ancker Hospital, St. Paul, Minn.

DR. JOHN D. SPELMAN, formerly superintendent of the Touro Infirmary, New Orleans, La., has been appointed to the superintendency of Montefiore Hospital, Pittsburgh, Pa., as the successor of DR. C. H. PELTON.

DR. CHARLES J. KOERTH is the newly appointed medical director of the Woodmen of the World War Memorial Hospital, San Antonio, Tex., succeeding DR. H. PHIL HALL.

CAROLINE M. BORCHERDING has resigned her position as superintendent of the Alachua County Hospital, Gainesville, Fla., after having served in that capacity for the past seven years.

DR. PAUL W. WIPPERMAN has resigned his position as superintendent of the Decatur and Macon County Hospital, Decatur, Ill., in order to fill the vacancy made by the resignation of DR. JOHN D. SPELMAN as superintendent of the Touro Infirmary, New Orleans, La.

DR. GEORGE F. BREWSTER, formerly superintendent of the Veterans' Bureau Hospital in the Bronx, New York, has been placed in charge of the Veterans' Hospital at Northport, L. I., succeeding DR. E. O. CROSSMAN who was appointed medical director of the United States Veterans' Bureau. DR. M. C. BAINES was transferred from the U. S. Veterans' Hospital, Augusta, Ga., to the U. S. Veterans' Hospital, the Bronx, New York, as medical officer in charge.

DOROTHY MATHEWS has been appointed to fill the vacancy left by FLORENCE WATERS who resigned her position as superintendent of the Easton Emergency Hospital, Easton, Md. Miss Mathews has had thirteen years of experience in hospital work.

DR. ERNEST E. BISHOP has been appointed to fill the position as assistant superintendent of the Hamilton County Tuberculosis Sanatorium, Cincinnati, Ohio, that was left vacant by the resignation of DR. PHILIP GATH.

DR. HARRY H. LANGDON is the newly appointed assistant superintendent of the Cincinnati General Hospital, Cincinnati, Ohio.

EDITH WAGNER, formerly night superintendent of the Graham Hospital, Canton, Ill., has been appointed temporary superintendent following the resignation of IDA HAHN who was superintendent.

CHARLOTTE GARRISON has accepted the appointment as superintendent of the Christian Welfare Hospital, East St. Louis, Ill., to succeed MRS. C. H. NIEDERFIELD.

DR. WALTER T. PARKER was appointed to succeed FANTINE PEMBERTON as superintendent of the Memorial Hospital, Owosso, Mich.

GRACE KLEIN has recently been appointed to succeed ETTA EASTERLING as superintendent of the Granada Hospital, Granada, Miss.

HELEN ALL has agreed to fill the vacancy left by G. K. GRUVER who has resigned her position as superintendent of the Community Hospital, Geneva, Ill.

Ohio Hospitals Average \$5.94 as Daily Operating Cost

The Miami Valley Hospital, Dayton, operates at a daily cost of \$5.04 for each patient, which is less than the average for private hospitals in Ohio, according to Dr. E. R. Crew, superintendent. The average daily cost per patient in Ohio hospitals, according to a recent investigation of private hospitals of 100 beds or more, is \$5.94. The report of the investigation shows that Lakeside Hospital, Cleveland, has the highest daily operating cost—\$8.57—and Grant Hospital, Columbus, has the lowest daily operating cost—\$4.58.

Increase Shown in Number of Beds in T. B. Sanatoriums

The National Tuberculosis Association, in preparing data for its "Tuberculosis Sanatorium Directory," has accumulated information showing that since 1904 the number of beds for tuberculous patients in the United States has increased from about 10,000 to approximately 73,000. Further information on this subject is given in an ar-

News of the Month

ticle in the *Journal of Outdoor Life*, which states that, according to Dr. Louis I. Dublin, New York, sanatoriums in this country are caring for more than 110,000 patients each year, and a conservative estimate is that 10 per cent of this number, or 1,100 lives are saved by the return to their communities of the patients of the preceding year. Dr. Dublin states that at least 800,000 patients have passed through these sanatoriums during the past decade, and that of this number about 606,000 are still alive and showing the benefits of their treatment. There are about 6,000 fewer deaths each year in this group than there would be if sanatorium treatment were not available.

Estimating the value of a human life at \$5,000, the savings in dollars to the communities from sanatorium treatment alone amounts to about \$30,000,000, which is about as much as the entire cost of maintenance of these institutions.

Chicago Nurse Chosen for Position at Cook County Hospital

Continuing her pioneer work in the field of nursing, Minnie H. Ahrens, R.N., will on October 1 assume the duties of assistant to the warden of the Cook County Hospital, Chicago, a position created for the purpose of coordinating, analyzing and reporting on the organization and service conditions in the medical, nursing and administrative sections of the hospital, according to a news note in the *American Journal of Nursing*.

Miss Ahrens is at present the executive secretary of District No. 1 of the Illinois State Association, a position she will relinquish when she goes into her new work. Miss Ahrens was also the first director of the Infant Welfare Society of Chicago. She is a graduate of the Illinois Training School for Nurses.

Nurses Will Meet in Montreal Next Year

More than five thousand nurses from all parts of the world are expected to attend the sixth regular meeting of the International Council of Nurses which will be held next July in Montreal.

"The essential idea for which the International Council of Nurses stands," according to information published in a recent issue of the *American Journal of Nursing*, "is self-government of nurses in their associations, with the aim of raising ever higher the standard of education and professional ethics, public usefulness, and civic spirit of their members."

At the last meeting of the council there were in attendance representatives from nineteen countries. This meeting was held in Helsingfors, Finland, in 1925.

It is said that Montreal was chosen as the location of the next meeting on account of its many attractions to tourists and students. It is a place of history and beauty. It has unusual facilities for handling large conventions, and is a place to which Europeans can easily adjust themselves.

Generous Gift Made to University of Pennsylvania

A gift of \$100,000 for the purchase of a gram of radium and accessories for use in the treatment of cancer has been received by the Hospital of the University of Pennsylvania, Philadelphia, and the department of radiology of the university's graduate school of medicine, from Col. Louis J. Kolb.

The fund will be designated the Louis J. Kolb Foundation for the Treatment of Cancer. About \$72,000 of the total amount will be required to buy the gram of radium and the balance will go toward the expenses involved in the clinical and medical research work with the radium.

Colonel Kolb's gift is the second one the University of Pennsylvania has received within the last eight months to aid in carrying on the fight against cancer, Irennee duPont having contributed a sum of \$45,000 last December for research in connection with the cause and treatment of the disease.

Dr. Bluestone Returning to United States

Word has been received of the departure from Jerusalem of Dr. E. M. Bluestone whose term of office as director of the Hadassah Medical Organization has expired. During the past three years Dr. Bluestone has contributed a great deal towards the progress of that organization which provides a majority of the medical service to the Holy Land.

During the year 1927 more than 10,000 patients were treated in the various hospitals in and about Jerusalem sponsored by the Hadassah Medical Organization, which is now entering its tenth year of existence. A change of administration is made every three years.

Coming Meetings

American College of Surgeons.

President, Dr. George David Stewart, New York.
Director General, Dr. Franklin H. Martin, 40 East Erie street, Chicago.
Next meeting, Boston, Oct. 8-12.

American Dietetic Association.

President, Florence Smith, St. Mary's Hospital, Rochester, Minn.
Business Manager, Dorothy B. Richmond, 25 East Washington Street, Chicago.
Next meeting, Washington, D. C., Oct. 29, 30 and 31.

American Public Health Association.

President, Dr. Herman N. Bundesen, Chicago.
Executive Secretary, Homer N. Calver, 370 Seventh Avenue, New York.
Next meeting, Chicago, Oct. 15-19.

Ontario Hospital Association.

President, R. H. Cameron, Women's College Hospital, Toronto.
Secretary-Treasurer, Dr. F. W. Routley, 410 Sherbourne St., Toronto 5.
Next meeting, Toronto, October 18 and 19.

Oklahoma Hospital Association.

President, Dr. L. E. Emanuel, Cottage Hospital, Chickasha.
Secretary, Mrs. E. E. H. Moore, Shawnee City Hospital, Shawnee.
Next meeting, Muskogee, November 22 and 23.

News of the Month

Commonwealth Fund Offers Fellowships in Psychiatry

The danger that incompetent and poorly trained men may be sent out as psychiatrists is a result of the existing lack of opportunities for an adequate training in this work. The Commonwealth Fund, however, alive to the situation, has come to the rescue by offering five fellowships which were made available in the department of psychiatry, Harvard Medical School, Boston. The Boston Psychopathic Hospital is affiliated with the school and the facilities of this institution will be placed at the disposal of the students.

Besides the fellowships in Boston three more have been granted for training in the University of Colorado Psychopathic Hospital, Denver. The fellowships at the Boston school will be given to men who have already shown unusual ability and interest in this line, and will be of three-year duration, with an opportunity to continue if the work done is of high enough grade. Facilities of various institutions will be available to them, and a period of study in a foreign clinic may be recommended. The fellowships at the Colorado school are of two-year duration.

Colored Hospital to Affiliate With the University of Chicago

Negotiations are in progress, it was learned recently, for the affiliation of the Provident Hospital for colored persons with the University of Chicago, contingent on the hospital obtaining an adequate building and sufficient financial support. It is not contemplated that the new building would be in the university clinic group on the Midway. By way of endorsement of the project Julius Rosenwald has contributed \$2,000 to be used for the out-patient department of the hospital during the period of transition.

In case of the affiliation, the University of Chicago would appoint the staff of the hospital, which will probably be partly colored and partly white, various of the university physicians being available.

New York Municipal Hospitals May Merge

A department of public hospitals in New York City may be created if a proposed plan to merge the municipal hospitals materializes, is the information contained in a news item in the *Journal of the American Medical Association*. This would mean the appointment of a commissioner of hospitals to rank with the other commissioners of the city and to hold office at the pleasure of the mayor.

The movement to unite city hospitals is said to be promoted by the New York Academy of Medicine as a progressive step in the treatment and prevention of disease, as well as efficiency and economy in administration. The three groups of hospitals affected include Bellevue and

Allied Hospitals; hospitals of the department of welfare; and hospitals of the department of health. Twenty-six hospitals are in these groups, with about 14,000 beds. The present system is criticized as being obsolete.

The board of estimate and apportionment has approved the proposed consolidation and the necessary ordinances have been prepared.

Classes of Instruction to Feature Physical Therapy Meetings

During the week of October 8 to 13, the seventh annual meeting of the American College of Physical Therapy will be held in Chicago, with headquarters at the Stevens Hotel. This meeting is being held in conjunction with the third annual Clinical Congress on Physical Therapy. The first two days of the meeting are to be devoted to instruction classes in physical therapy, and the last three will be taken up with addresses, demonstrations and clinics.

Among the speakers will be Dr. Carl Sonne, Copenhagen, Denmark; Professor Donato de Francesco, Venice, Italy; and Dr. Alfred R. Friel, London, England. In addition to these noted men about 100 clinicians and teachers will take part in the program.

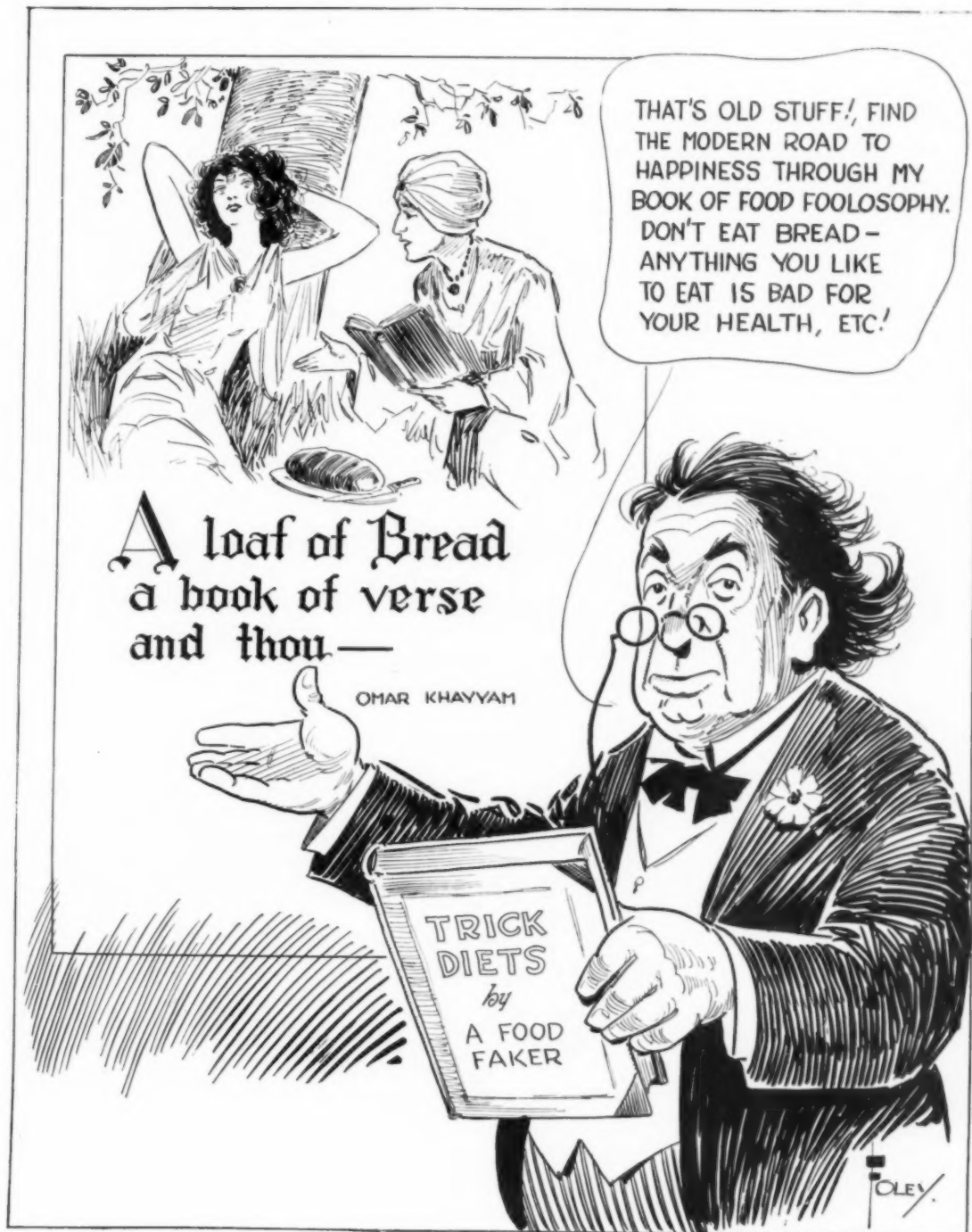
Free Barber Service to Patients Is New Bureau Order

Free barber service will be furnished all patients in the U. S. Veterans' Bureau hospitals who are not in receipt of compensation, according to a recent decision by Gen. Frank T. Hines, director of the bureau, it is announced by the national rehabilitation committee of the American Legion. Hair cuts and shaves have heretofore been provided gratis to indigent patients in the bureau's neuropsychiatric hospitals, and this service will now be extended to all patients who are unable to pay.

The bureau is now getting out a letter of instructions covering this matter, to the commanding officers of all its hospitals. The plan provides that the barber service must be prescribed in each case by the ward surgeon having contact with the patient. Heretofore it has been necessary for American Legion posts, auxiliary units and other outside agencies to supply the money for this important item. In view of Director Hines' action this will no longer be necessary.—*Chevrons*.

Additions Planned for Milwaukee Children's Hospital

Preliminary studies are being prepared for an additional building for the Milwaukee Children's Hospital, Milwaukee, to accommodate an enlarged out-patient department and provide additional beds. Fitzhugh Scott, A. I. A., Milwaukee, is the architect and T. B. Kidner, New York City, the consultant.



This cartoon is published in an effort to awaken the public to the danger of following the literature and advice of food faddists or fakers when they should depend on a licensed doctor or dietitian for correct diet information. ☞ To anyone interested, we shall be glad to mail, without charge, a copy of "Facts About Bread and its Rightful Place in the Diet"—a booklet containing statements by the country's most eminent nutritional authorities. ☞ Address Dept. 362, Washburn Crosby Company, millers of Gold Medal Flour, Minneapolis, Minnesota.

News of the Month

Research Center Planned for St. Louis

Plans for the construction in St. Louis, Mo., of a new eye, ear, nose and throat hospital as an addition to the Washington University group have met with great enthusiasm. Of the \$4,000,000 needed for construction and endowment of the proposed institution \$2,700,000 has already been raised in two gifts. A donation of \$1,200,000 was contributed by the late Mrs. William McMillan, for whom the hospital is being named, and an offer of \$1,500,000 was made by the General Education Board on condition that another million was raised elsewhere.

The site for the new hospital is to the east of the new St. Louis Maternity Hospital. This will be the first hospital of the Washington University group that will be open to any reputable specialist.

The McMillan Hospital will be a nine-story building, with wards on the fourth floor, private rooms on the fifth, research laboratories on three of the upper floors, clinics on the lower floors and facilities for graduate work.

Varied Program Features Catholic Hospital Conference

A most successful meeting of the Missouri-Kansas Conference of the Catholic Hospital Association was held in Wichita, Kans., September 11, 12 and 13. Sisters Superior and department heads of Catholic Hospitals of Missouri, Kansas and Oklahoma were present, and at the business session of the meeting it was decided to change the name to the Midwest Conference of the Catholic Hospital Association.

At the first meeting on Tuesday morning Father Alphonse M. Schwitalla, S.J., the newly elected president of the Catholic Hospital Association, presided. The Rt. Rev. Monsignor W. M. Farrell, LL.D., Mayor Frank Dunn, Dr. C. A. Parker, president, Sedgwick County Medical Society and Allen W. Hinkle, president of the chamber of commerce, gave short addresses of welcome. This was followed by the presidential address given by Sister Rose Victor, Providence Hospital, Kansas City, Kans., president of the Missouri-Kansas Conference. Luncheon was served in the cathedral school dining hall, and at the afternoon session, papers were presented by Sisters of Kansas hospitals, with Sister Rose Victor presiding. The development and maintenance of interhospital contacts; the intern problem in hospitals; administrative problems of emergency cases; the administration of the school of nursing in small hospitals and other subjects were discussed.

The Wednesday session was presided over by Sister Mary Giles and the first speaker was John A. McNamara, executive editor, *THE MODERN HOSPITAL*, who substituted for Dr. Malcolm T. Mac Eachern, associate director, American College of Surgeons, Chicago, who was unable to be present. Mr. McNamara discussed the small hospital, mainly from administrative angles. His paper was followed by an address by Father C. B. Moulinier, S.J., executive director, Catholic Hospital Association, who spoke on "The Hospital's Viewpoint."

Father Schwitalla was the third speaker. He discussed the relation of the physician to the hospital. An excellent address by Dr. Ralph Kinsella, professor of internal medicine, St. Louis University, St. Louis, was the last paper of the session. The morning session was closed with the answering of many questions presented by the Sisters present.

Luncheon was again served in the school dining hall, and in the afternoon the program was resumed. Mr. McNamara presented the subject of cost and charges in Catholic hospitals, based on a study of 251 Catholic hospitals in the United States. Helena A. Dunham, R.N., supervising nurse, Jackson County Health Department, Independence, Mo., read a paper on "The Correlation of the Community Hospital With Health Organizations." This was followed by ten-minute addresses by physicians and prominent health workers of Wichita, and the session was closed with an address by Father Moulinier.

Thursday's session was given over to laboratory and nursing problems, with papers presented by Sisters of the Missouri hospitals, with Mother Concordia of St. Mary's Infirmary, St. Louis, acting as chairman. Hospital and school health problems were discussed at the closing session on Thursday afternoon.

Fulton County, Ohio, Gets New Community Hospital

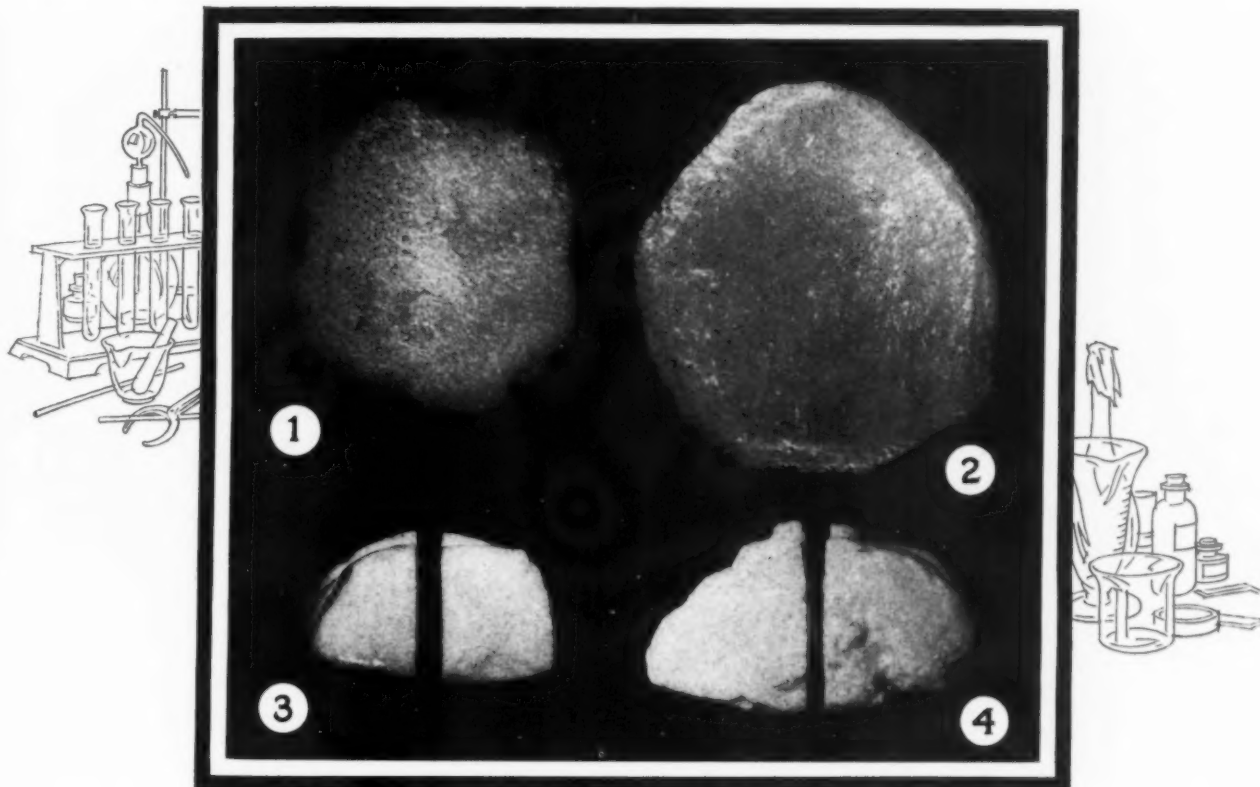
The DeEtte Harrison Detwiler Memorial Hospital will be the name of the new community hospital to be built in Fulton County, Ohio, and for which funds to the amount of \$240,000 have been raised. The hospital is to be built on a site south of Wauseon. In addition to a gift of \$80,000 from A. K. Detwiler, the hospital will receive \$160,000 from the Commonwealth Fund of New York City. The operating room is to be named in memory of Dr. Andrew J. Murbach, pioneer Fulton County physician.

New Hahnemann Hospital Ready for Occupancy by November

It is expected that the new Hahnemann Hospital, Philadelphia, will be ready for occupancy by November, and in anticipation of this, John M. Smith, director of the institution, has been trying to decide what is the best method of transferring the bedfast patients from the old to the new building.

Furnishings for the new building have not as yet been chosen, but a large room in the old building has been given over to exhibit space, and the prospective contractors for furniture and equipment for the new unit have set up model rooms for the trustees to look over. Mr. Smith has been visiting various new hospitals in the east with a view to collecting data that will help him in equipping the new Hahnemann Hospital.

When the old building has been vacated, alterations will be made on the structure and it will be utilized as a college building.



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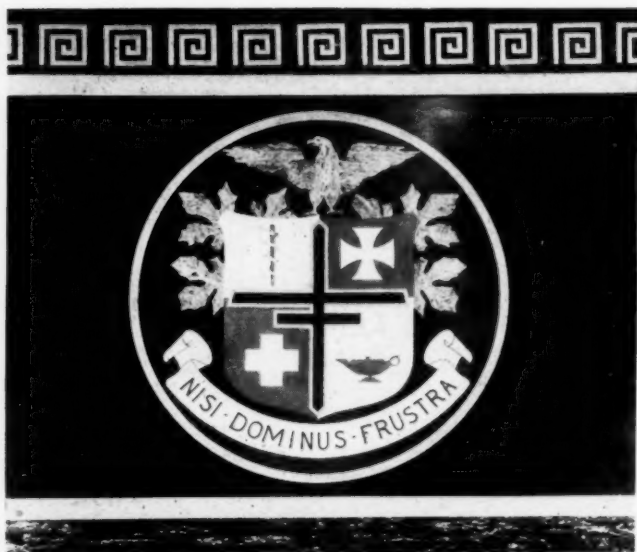
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News of the Month

A. H. A. Emblem Displayed at Meeting

The emblem of the American Hospital Association was prominently displayed at this year's meeting in San Francisco. A garden of flowers which formed the design at Golden Gate Park drew many favorable comments from



the delegates and presented a beautiful sight. In one of the booths on the exhibitors' floor of the convention hall the design was again prominently displayed by means of an inlaid, reinforced, rubber mat, which had been finished in colors.

Chicago Dietitians Hear Talk on Equipment

The September meeting of the Chicago Dietetic Association was held in the Lakeview Building on Wednesday, September 19.

Owen T. Webber, engineer, Webber and Wells, Chicago, gave a talk on equipment.

Following Mr. Webber's address, there was an informal discussion on the teaching of dietetics to student nurses. Questions were asked from the floor and teaching methods were described.

New Medical Unit to Be Added to University of Pennsylvania

The University of Pennsylvania recently broke ground for the erection of the new Martin Maloney Memorial Clinic Building of the University Hospital, which will occupy the site of the old Pepper Laboratory of Clinical Medicine, and will cost slightly more than \$1,000,000.

Constituting the first unit in the eventual complete

modernization and expansion of the University Hospital, the new structure will permit the concentration of a number of important medical clinics in accordance with the latest practice in medical science.

The building, which will house the general medical outpatient department of the University Hospital, will be L-shaped, nine stories high, and of red brick and Indiana limestone, decorated with terra cotta.

The architecture is English Collegiate, modified to suit the demands of a building of the type contemplated and treated in a slightly modern fashion in accordance with the rapidly developing distinctive features of American architecture. The clinic will face 100 feet on Spruce Street and will extend along Thirty-sixth Street to a depth of 157 feet, forming the right wing of the University Hospital, to which it will be joined by a five-story connecting building.

Veterans' Hospital Occupies New Buildings

The neuropsychiatric hospital, Roxbury, Mass., leased by the Veterans' Bureau since 1922, has been closed following the transfer of 263 patients to the new hospital at Bedford, Mass.

The Bedford Hospital was recently completed for the Veterans' Bureau at a cost of approximately \$1,500,000. It consists of twenty buildings and at present has 350 beds. It was built to allow for a possible increase in beds to from 800 to 1,000.

The bureau is replacing the leased hospital facilities with permanent fireproof buildings as rapidly as is compatible with good administration and as funds are available, according to the announcement.

Preventorium Opened at Grasslands

The Westchester County Preventorium opened at Grasslands Hospital, Valhalla, N. Y., August 1, 1928. The work is under the direction of Dr. Joseph E. Strobel, director of the tuberculosis division.

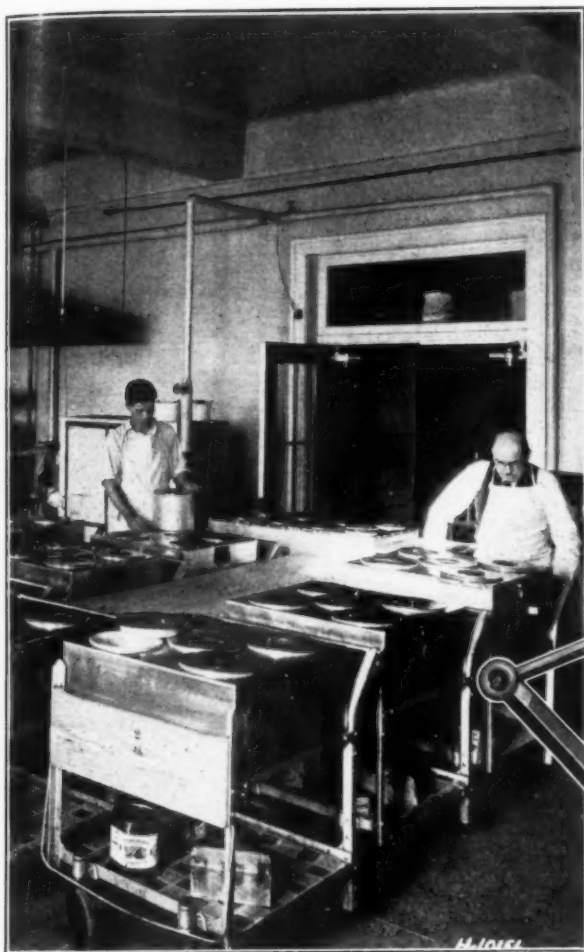
There are accommodations for thirty-five children—eighteen boys and seventeen girls, ranging in ages from four to twelve years.

A graduate nurse is in charge of the children assisted by a recreational worker. The nutrition work is under the direction of the nutrition department of the hospital and special emphasis has been placed on this side of the program.

Plans have been made to have any corrective work necessary taken care of during the child's stay in the preventorium.

The minimum length of stay is three months. However, a child needing a longer period of supervision will not be discharged until the doctor feels his physical condition warrants it.

Although the preventorium is primarily for children exposed to tuberculosis, cases of malnutrition will be admitted.



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News of the Month

Indiana Executives Plan Next Convention

The officers of the Indiana Hospital Association recently held a luncheon meeting in Indianapolis to make plans for their 1929 convention.

It was unanimously agreed to hold the next convention in Indianapolis, on April 11 and 12.

Those attending the luncheon were as follows: Dr. Bert W. Caldwell, executive secretary, American Hospital Association; Albert G. Hahn, president, Indiana Hospital Association, Protestant Deaconess Hospital, Evansville; Gladys Brandt, Cass County Hospital, Logansport; Dr. William A. Doeppers, City Hospital, Indianapolis; Missouria F. Martin, R.N., Muncie Home Hospital, Muncie; Mrs. Hazel B. Presser, Howard County Hospital, Kokomo; Mary Elma Thompson, Methodist Hospital, Princeton; Mrs. Elizabeth Covert, Bartholomew County Hospital, Columbus; Anna Johnson, Indiana State Sanatorium, Rockville; Edward Rowlands, James Whitcomb Riley Hospital, Indianapolis; Adah B. Strayer, Wabash County Hospital, Wabash; Mrs. Ethel P. Clarke, R.N., Indiana University Hospitals, Indianapolis; Mrs. Luella Cox, Methodist Episcopal Hospital, Gary; Dr. Charles N. Combs, Union Hospital, Terre Haute.

New Beth Israel Hospital Dedicated in Boston

The dedication and inauguration of services in the new 180-bed Beth Israel Hospital, Boston, Mass., took place recently. It is a general hospital equipped for teaching and research, and some of the instructors are associated with the Harvard Medical School which is nearby. The out-patient department has ten clinics and is capable of serving about 20,000 patients a year. There are basal metabolism and electrocardiographic laboratories, an animal research department and an extensive roentgen ray department. Dr. Charles F. Wilinsky is superintendent of the hospital, which, it is said, will be open to all patients regardless of race or religion.

American Women's Hospitals Provide Service in Greece

The work done all over the world by the American Women's Hospitals during the past five years has been highly praised by medical authorities. In Greece, however, where it has been necessary to serve the 1,500,000 outcasts from Turkey who are striving to establish their homes on the Peninsula, the work has been heaviest, and here the hospitals have proved their worth by the wonderful results they have achieved. In several large cities the only hospital facilities available are those provided by the American Women's Hospitals.

With the people as unsettled as they are it would, of course, be impractical to build permanent hospital buildings. For this reason the hospitals and clinics are established in rented buildings or temporary structures, and are moved about from place to place to meet the needs for the service they render.

In many of the stations the services of refugee doctors and nurses are accepted.

Although the Refugee Settlement Commission helps to support the different medical centers in Greece, the greatest part of the burden is carried by the American Women's Hospitals through funds provided by the American people. A summary of the work in Greece in 1927, as given by Dr. Esther Lovejoy, chairman of a committee of the Medical Women's National Association (which recently inspected the hospitals in Greece), shows a total of 45,719 patients cared for, of whom 4,539 were hospital patients.

Cottage Hospital, Santa Barbara, Receives Large Donations

Gifts totaling more than half a million dollars have recently been made to the Cottage Hospital, Santa Barbara, Calif., to be used for research work, according to an announcement by the board of directors. Among the donors are Max C. Fleischmann, George O. Knapp, and Edward L. Harkness, each of these giving \$200,000; Edward Lowe, who gave \$5,000, and E. Palmer Gavitt who gave a new building which is to be devoted to research. The gifts of Mr. Harkness and Mr. Knapp are to be invested and only the income used for research, while a certain amount of the Fleischmann donation will be used for needed improvements to buildings and the remainder invested.

To Replace Another Unit of Bellevue Group

A new psychopathic hospital to take the place of the old structure now a part of the Bellevue and Allied Hospitals, New York City, will be erected by the city. Plans for the construction of this large building were filed recently and call for an estimated expenditure of \$3,750,000. The new building will be nine stories high.

The filing of plans for the new hospital building is another step in the relocation of the entire hospital group, some parts of which have occupied their present sites since 1808. The site of the new unit is bounded by First Avenue, Twenty-ninth Street, Thirtieth Street and the East River.

Hospital Crippled By Storm Serves Victims

When the recent hurricane swept Porto Rico, causing heavy damages in San Juan, the Presbyterian Hospital there was not spared from its ravages. The roof was torn from the building, windows were broken and other damage was done. Regardless of this handicap, however, the hospital continued to serve the hundreds of people who swarmed there to have their injuries attended to. The Presbyterian Hospital was a beautiful three-story structure having sixty-one beds. Jennie Ordway is superintendent. The staff of the hospital gave prompt and efficient response to the needs of the people during the crisis.

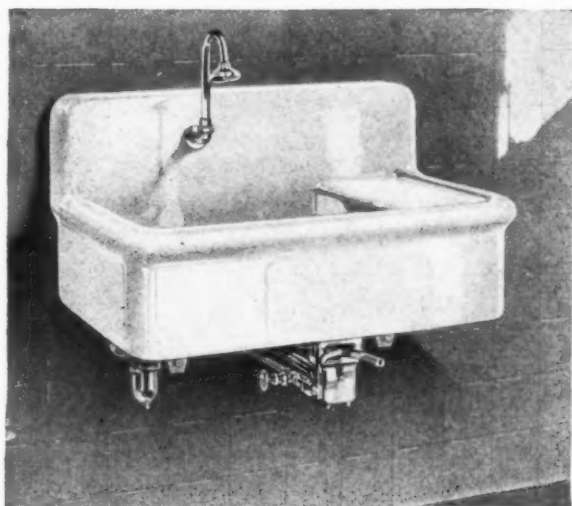
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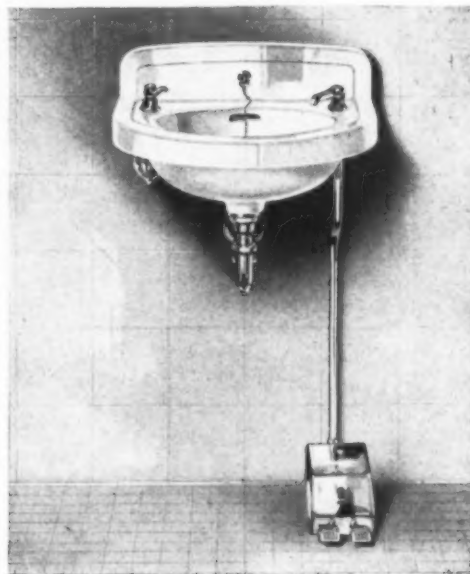


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NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

Applying Professional School Methods to Nursing Education

By CHRISTOPHER G. PARNALL, M.D.

Medical Director, Rochester General Hospital, Rochester, N. Y.

THE hospital training school of the past was well named. It was conducted largely as a means of obtaining nursing help cheaply. Nurses turned out under such a subterfuge for professional training were about what one might expect—good, bad and indifferent, depending upon the initiative, educational background and moral character of those who chose nursing as a career.

The requirements for entrance to a "training school" were anything from strong backs to average intelligence and a willingness to endure from two to three years of servitude. It is only within recent years that nursing has been recognized on the basis of a profession and that any attempt has been made to provide sound educational preparation. Even now, in a great many nursing schools the highest aim is to qualify under the state laws requiring registration and prescribing curricula.

Nursing Service too Casually Planned

Nursing in the hospital has been casually organized despite its importance as a major activity of the hospital. Various plans are in vogue. In some hospitals nursing in all its aspects is under the domination of the hospital executive. In some hospitals the training school is run as a rival enterprise under a superintendent of nurses, whose authority comes from the governing board or, vicariously, through an advisory group of women. In still other hospitals nursing is controlled by a nursing committee consisting of representatives of the trustees, the women's advisory board and the staff. None of these plans has proved altogether satisfactory. Nursing in the hospital has two distinct aspects, both of which must be clearly understood if a satisfactory organization is to be brought about.

1. Nursing service to patients: This is distinctly a hospital function and should be organized as a hospital department in charge of the chief nurse executive who in turn is responsible directly to the hospital executive.

2. Nursing education: This, as the term indicates, is strictly an educational function. An educational department should be autonomous and its administration preferably should be by those concerned in teaching.

When a hospital school of nursing is regarded merely

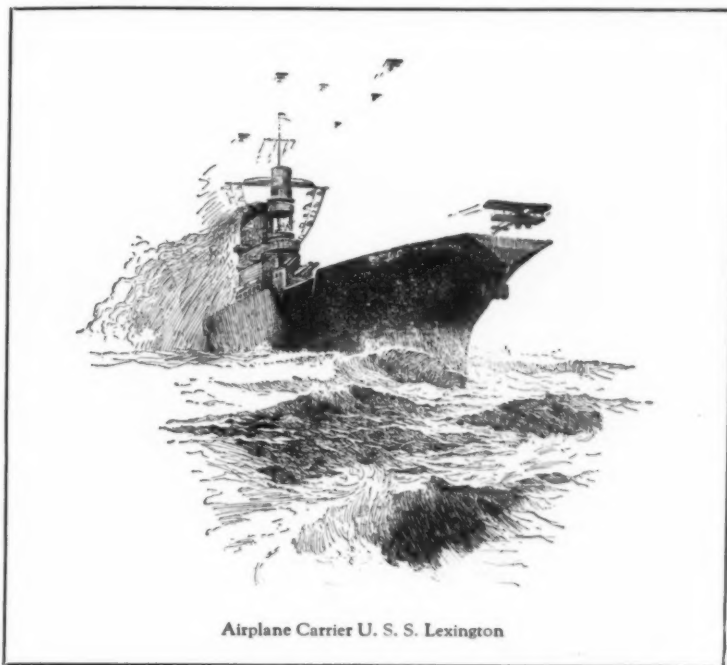
as a department under the control of the superintendent of nurses who is responsible to the hospital superintendent, a certain amount of antagonism always exists between the medical and nursing groups. This is largely the result of a lack of understanding on both sides. Members of the medical profession generally have been slow to realize the problems the nurses have been called upon to solve. Members of the nursing profession have felt that the doctors were not altogether to be trusted and have hesitated to take them into their confidence.

Since the problems of nursing education are essentially the same as those met in preparing for other professions, the methods in use in professional schools can, with modifications, be applied successfully to nursing education. This is believed and practiced at the Rochester General Hospital. When the by-laws were undergoing general revision it was provided that, while the nursing service as heretofore should remain an executive department of the hospital, nursing education should become the responsibility of a nursing faculty.

This faculty consists of those who are chiefly concerned in the teaching of nurses. Its membership is made up of the following: representatives from the major medical services, general medicine, surgery, obstetrics and pediatrics; the chairman of the medical board, ex officio; the director of nursing, who is also principal of the school; the assistant principal; the instructor in theory; the instructor in practice and a public health nurse who has achieved distinction in her field. The remaining members are the director of laboratories, the chief resident physician, the medical director of the hospital, the head of the social service department and the teaching dietitian.

This faculty exercises all of the functions and powers and enjoys all of the privileges of the faculty of a professional school. Educational policies are entirely within the control of this group. Each member has precisely the same authority as any other member. The principal of the school is the executive officer of the faculty and the medical director of the hospital acts as chairman.

It would be highly desirable for the school to have an independent budget based on a separate endowment. However, recommendations made by the faculty have



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always been approved by the hospital administration and funds have been relatively adequate.

The results of instituting the plan outlined have apparently justified its adoption. It has been in effect for three years. Nursing education in the hospital is now regarded as a cooperative enterprise. The nursing group has found that the doctors are perfectly reasonable if they are given a chance to understand, the members of the medical staff have found that the nursing problem has a side with which they were not familiar, and the administration is relieved of a responsibility that it properly should not assume. The experience at the Rochester General Hospital with this plan of organization for nursing education seems to justify its trial by other hospitals.

Schools for Men Nurses Show Little Advancement

Out of the vast number of nurses who went forth into active duty from the 2,155 nurses' training schools of the country, only forty were men, according to an article in *The Trained Nurse and Hospital Review*.

"The forty years that have ensued since the Mill's Training School for Male Nurses, New York, was founded, have not been productive of much advancement in the matter of training competent male nurses," the article points out. "The American Medical Association's report of hospital service lists but twenty-nine schools of the existing 2,155 nurses' training schools as schools for the training of men nurses. Of these twenty-eight are co-educational, the one at the Alexian Brothers Hospital, Chicago, being the only one for men nurses only. About 202 men were enrolled in these hospitals last year, of whom approximately forty were graduated."

Dr. George O'Hanlon, general medical superintendent, Bellevue Hospital, New York, in addressing a meeting of the American Hospital Association accounted for the relatively small number of men nurses in these words: "The position of the male nurse is analogous to that of the woman in medicine. We all agree that there is a field for their service but do little or nothing to encourage its development. Why? Again it is the barrier the woman in medicine has to overcome—prejudice."

The Hospital Is Responsible for the Nursing School

Nurse training schools have expanded to great proportions despite the unbelievable opposition they have encountered since the establishment of the first school in 1873. The medical staffs of the hospitals were at first so opposed to the training schools that they refused co-operation entirely, and the schools were forced to rely upon outside help and influence for their maintenance. In the passing years noticeable progress was made by the schools and their services received the recognition of the hospitals. The low cost of the services rendered in the hospital by these nurses as a means of paying for their training especially appealed to the managers of the institutions, and it came to be expected that when a new hospital was opened a school of nursing would be incorporated.

Briefly this is the account given by Dr. George O'Hanlon, superintendent, Jersey City Hospital, Jersey City, N. J., of the rapid growth of nurse training schools

in an article in a recent issue of the *American Journal of Nursing*. The responsibility of the hospital to the training school, however, is not fulfilled when the hospital provides a place for the nurses to practice and a course of study that is just broad enough to cover the work carried on by the hospital, he pointed out.

Many hospitals have established wonderful schools as far as the service rendered to the hospital is concerned, but a great many have failed miserably in their responsibility to the school—the education of nurses.

"The thing that concerns every educator and hospital administrator," said Dr. O'Hanlon, "is whether or not we are turning out graduates who meet the requirements of the state, who can intelligently carry out doctors' orders, and who can render satisfactory nursing care to the sick. It is in the solution of this problem that the responsibility of the hospital lies."

Whether the nursing school is an integral part of the hospital or not, the hospital is responsible for it. The staff members must give lectures; consideration must be given to the nurses' health; healthful study rooms and sleeping quarters must be provided; care must be taken that the nurses are not overworked; and the school should be allowed enough freedom from hospital control so that the development of its highest function will be possible at all times.

Do Hospitals Give Their Best Toward Nurse Training?

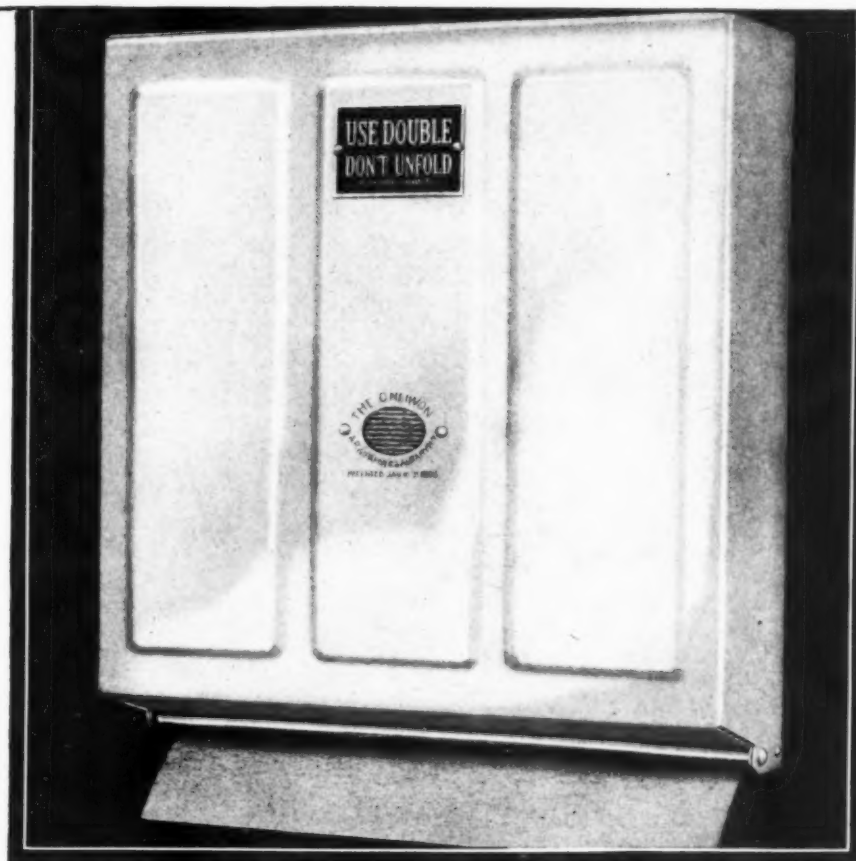
If all nurse training schools were located in hospitals with equipment and facilities of the most modern type, which covered almost every reasonable scope of the treatment of patients, the problem of educating nurses would demand no such complicated solution as it now does, is the essence of a paper read by Dr. May Ayres Burgess, director, Committee on the Grading of Nursing Schools, before the American Hospital Association. The training given to nurses in most schools is adequate to equip them for work in the hospital where the school is established, but apparently little thought is given to educating them for any other field they might wish to enter after graduation, is Dr. Burgess' contention.

"When it is considered that one-third of the hospitals in this country are training most of the nurses for the other two-thirds, and that from the graduates of these schools must be chosen the general floor duty nurses, specials, head nurses, supervisors and superintendents of nurses for all the remaining institutions, the problem of providing an adequate and thorough education for nurses looms up as one of great importance," she points out.

"The hospital, it is generally conceded, trains nurses for institutional service," Dr. Burgess emphasizes. "Statistics show that only one-fourth of the graduates from accredited schools continue with institutional work. Most of them go into private duty and a great many find public health work both interesting and profitable. Yet the hospitals continue to neglect training in either of these fields."

"Aside from the fact that the hospitals fail to give instructions to the nurses in any other than institutional work, it has been found that most schools train the nurses in the use of only those facilities that are provided by the hospital in which the school is located. Thus, if a graduate were to go to some larger or more completely equipped institution, she would be apt to find herself lost and unable to establish herself in the new surroundings for some considerable time."

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Sane Dietary Habits Characterize the Scotch

By MARGARET M. FOTHERINGHAM

The Colonial Hospital, Rochester, Minn.

FOOD habits and customs of Scotland like those of all other countries are influenced to a great extent by geographical position, climate and population.

Scotland has an area of about 33,000 square miles, one-third the size of the state of Minnesota, with a population of six million people, which is about three times as great as that of Minnesota. The thermometer seldom goes below twenty degrees Fahrenheit, or above eighty, which gives the country an unusually mild climate.

Nowhere in Scotland can one get more than fifty miles away from the salt water, either the Atlantic Ocean or the North Sea, a natural result of which is plenty of rain and humidity, produced by the warm ocean breezes as they strike the colder hill tops and condense. In some parts of the highlands the land is so rocky and wet that ditches have been dug into the hillsides to drain the excess moisture. This land can be used for sheep raising. In other parts where it rains almost constantly the ditches are of no avail and the land stands idle.

Domestic Foodstuffs Not Sufficient

Scotland, like many other European countries, cannot produce sufficient food for her large population. This is due to the excessive moisture and the large areas of barren land.

Some oats, corn as this grain is called in Scotland, are raised but most of the grain is imported, the wheat coming from the United States and Canada.

Fruits and vegetables are imported from the Channel Islands, France, Spain, Italy and Algiers. The vegetables that grow best in Scotland are potatoes, which can be imported from Ireland if the crops are poor, cabbage, turnips, beets, cauliflower, onions and string beans. Tomatoes are cultivated in greenhouses, and a small amount of lettuce is grown during July and August. Berries, the principal fruit grown, are luscious. The berries include currants, raspberries, strawberries and gooseberries, which are sweet and as large as our cherries. Heather and clover honey are produced in large amounts, the heather honey being much richer in color and flavor than the clover honey.

The highland cattle of the north and the Ayrshire cattle of the south furnish some of the finest ox meat in the

world. Parts of the Highlands are also used for sheep raising. The temperature is usually so mild that the cattle and sheep can be pastured on the hillsides both summer and winter. To meet the demands of the population, a large amount of meat is imported from Australia and New Zealand.

Fish, practically the only food not imported, is eaten two or three times daily. This is always salt water fish and can be caught or bought fresh every day. The fact that the people live so near to the sea level and eat so much fish, undoubtedly accounts for the absence of exophthalmic goiter in Scotland.

The average consumption of milk per capita in Scotland is practically the same as in the United States. Adults do not use it as a beverage but get sufficient milk on their porridge, their fruit desserts or tarts and in their tea. Scotch butter is usually unsalted. A large amount of this commodity is imported from Denmark and Ireland. Either domestic or imported cheese is served with crackers at the end of luncheon or dinner.

The drinking water of Glasgow is soft because of the lack of lime. This has been given as the cause of the prevalence of rickets among the children of the poorer classes there, but the lack of sunlight and the crowded living conditions among the poor are more likely to be the real causes of the disease.

Rickets Caused by Cramped Posture

In the slums of Glasgow another contributing factor to rickets in the children is the manner in which mothers carry their babies. The baby is held in the left arm and wrapped in a shawl which comes over the mother's left shoulder, across her back, under her right arm and is held in place with her left hand. This helps to relieve the mother of the weight of the child and allows her to use her right hand, but the baby is forced to spend the greater part of his first year in this cramped position. Children's clinics are trying to overcome this custom by advising the mothers to buy coats rather than shawls.

Child welfare and public health work are being carried on along the same general lines as in this country. The hospitals, known as infirmaries, are for the working classes, who are given free medical care. These hos-

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pitals are supported by voluntary contributions from factories, industries or private individuals, and are governed by a board of managers who are elected locally. Patients who are able to pay go to private nursing homes.

The Royal Infirmary, Edinburgh, is the only hospital in Scotland that has a dietitian. This department had been opened only about two months when I visited there. The dietitian has supervision of the special diets only. Improvised accommodations were being used, while the department was being built, in an old wing of one of the buildings. The special diet kitchen will be a large outside room on the ground floor, next to which will be the dietitian's office.

"Diabetic Cabbage Kettle"

The dietitian will plan the diets but the bulk of the food will come from the main kitchen. This kitchen is in charge of a woman who is a graduate of a school of domestic science, as are her assistants. Each assistant had charge of some specific part of the work. One assistant is in charge of the "diabetic cabbage kettle." This was practically the only vegetable that was cooked for the diabetics, as they all enjoyed cabbage and were able to buy it when they left the hospital. The evening I visited this hospital the weekly diabetic clinic was held. This was attended by about seventy persons who worked during the daytime. The dietetic out-patient department consisted of a large waiting room, the dietitian's office, a laboratory for urinalysis and a large demonstration room. An analysis of oatmeal cakes and scones for the use of diabetics was being completed. These foods partially take the place of bread in the Scotch dietary.

Scones resemble our soda biscuits in composition. They are round cakes as large as a dinner plate and about three-fourths of an inch thick. These cakes are cut into triangular pieces, like a pie, and are baked on an iron griddle on the top of the fire. They are eaten cold with butter and jam or marmalade. Oatmeal cakes are flat, brittle cakes made of finely ground oatmeal, browned on an iron griddle, and then baked until crisp in the oven or before an open fire.

The Scotch people eat four times a day. Their meals consist of breakfast, dinner, afternoon tea, supper, and perhaps tea again later in the evening. The custom of tea drinking is possibly due to the cool, damp climate and it is over the teacups that the delightful cordiality of the Scotch people is most apparent.

The Scotch eat a higher calorie diet than the American people, due largely to the climatic conditions. Proteins and concentrated carbohydrates supply the increased calories. Green vegetables are used in limited amounts, but cabbage, raw or cooked, is eaten almost daily. The whole cereals, natural fruit sugars, and honey have an important place in the dietary. Cooked fruits and fruit puddings take the place of rich pies and pastries. Dairy products are used liberally. Consequently the diet is not only high in calories but in the protective foods that are so essential to the well-being of this hardy nation.

A Sample Menu

Breakfast

Scones, oatmeal cakes, or bread with marmalade
Porridge with rich milk
Fish
Bacon or eggs
Tea

Dinner

Scotch broth
Roast mutton

Boiled potatoes
Buttered cabbage
Gooseberry tart with milk
Crackers with cheese
Bread, cakes

Afternoon Tea

Bread and butter sandwiches, jam or marmalade
Scotch cakes
Tea

Supper

Fish
Bread, scones, oatmeal cakes with marmalade
Stewed fruit and milk
Cheese and crackers
Cake
Tea

Alberta Advisory Committee to Investigate Health Conditions

Appointment of the members of the newly created advisory committee to the Public Health Department of Alberta, Can., was recently announced by the Hon. George Hoadley, minister of health of that province, as follows:

Representing the medical profession at large, Dr. W. A. Wilson, Edmonton; representing the College of Physicians and Surgeons, Dr. George Johnston, Calgary; representing the Faculty of Medicine, University of Alberta, Dr. Edgerton Pope; the medical health officers of the province, Dr. Gow, medical officer of health, Calgary; the superintendents of city hospitals, A. T. Stephenson, Red Deer; representing laymen, H. E. Scholefield, Calgary, and one to be selected; representing the women, Mrs. O. C. Edwards, Macleod, vice-president, Canadian Council of women, and Mrs. Field, Spurfild. One representative of the nurses is yet to be nominated.

A dental advisory board which will function in the same capacity for the dental profession has also been appointed, it was announced.

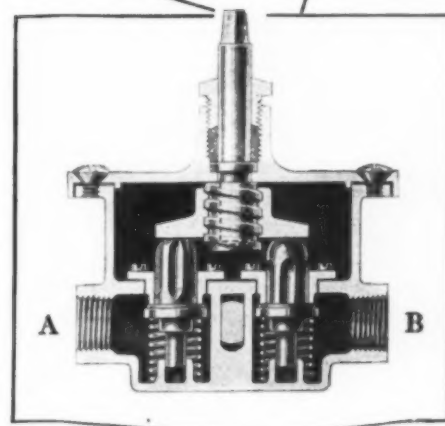
The object of the board is to advise the minister on matters pertaining to health conditions in the province.

A Legal Opinion

In the case of *Nichita v. the City of New York*, 233 App. Div. 428; the plaintiff was struck by an ambulance owned by the defendant city and used in connection with a municipal hospital. At the time of the accident the ambulance was being used to convey a class of nurses to a clinic at which they were to receive instruction. The hospital and the ambulance were under the jurisdiction of the department of public welfare and the hospital was conducted as a charitable institution. It was held that since the automobile was being used by the defendant in the performance of governmental functions imposed by law upon the municipality for the welfare of the people of the state and in furtherance of the charitable purpose of the hospital established and maintained to render service to the public, the city is not liable for the negligence, if any, of the driver of the automobile. The distinction between governmental or state functions cast upon a municipality by law for the benefit of the state in the exercise of which power the municipality may not be held liable for negligence, and those conferred primarily for the private advantage of a compact incorporated community, is discussed in the opinion.



NEW
Diagram shows New Clow "Triumph" mixing valve. Cold water valve at right opens first; the water enters at B. Hot water valve follows; the water enters at A. Cold water valve shuts off before the hot water is full on. Note how water presses *with* the closing of this valve—not against it. Note also phosphor bronze springs which help closing of both valves.



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Sprue Patient Must Look to His Diet at All Times

By FRANCES BERKELEY FLOORE

Dietitian, University of Michigan Hospital, Ann Arbor, Mich.

WHILE sprue is primarily a tropical disease it is often found in the United States, especially among those who have contracted it in the West Indies, South America or India and have returned to this country hoping for a cure. Sprue is often confused with pernicious anemia and this is not surprising in view of the similarity of the two.

The reason why some Americans can live for years in the tropics and not get the disease, and why others get a touch of it during just a brief sojourn there still remains one of the puzzling problems of sprue. There are theories as to its cause, namely, living under tropical conditions, but too much emphasis cannot be placed on this factor when we consider that sprue is not found in all tropical countries. In this connection there is the germ theory, monilia psilosis, discovered by Dr. Ashford, but this is not found in all cases of sprue. Monilia psilosis is also found in a few cases of pernicious anemia. Many people adopt a high carbohydrate diet when living in a tropical country, but this is considered an unwise thing to do, because it undermines the health and lowers the resistance to sprue.

The symptoms of sprue are sore tongue, diarrhea, loss of weight and anemia. Many times sprue patients are unable to take any food but milk or broth because of sore tongues. The tongue usually clears up with proper treatment, but the soreness returns if there is a lapse in the diet. Diarrhea is usually one of the pronounced symptoms and because of this and the inability to assimilate fats and carbohydrates the patients often lose much weight and become thin and anemic. A mental depression and a nervous irritability often accompany these symptoms.

Milk Diet Is Prescribed

The treatment is fundamentally dietetic, and though the medical treatment is important, it is of no use without diet. The patient is first put on a milk diet and allowed eight ounces of milk every three hours. He is kept on this diet until the diarrhea is checked, which is usually within three or four days. During this time the patient loses in weight, although he quickly regains it when the diet is renewed. Phenomenal gain or loss of weight is one of the characteristics of sprue.

The outstanding characteristic of the sprue patient is his inability to assimilate fats and certain carbohydrates. In the tropics this statement can be modified because the sprue patient there can digest and assimilate certain tropical foods that are rich in sugars, such as the platano, yautia, banana and papaya. For this reason it is easier to treat sprue in the tropical countries where the disease usually originates because the added foods lend palatability and variety to the diet and increase the caloric value as well.

After the milk diet has been continued for several days other foods are cautiously added. The fourth day a baked ripe platano may be given and the next day a

vegetable, platano and grapefruit and so on until a 2,000-calorie diet has been reached, with milk always the basis of the diet. If the patient is able to assimilate this amount of food and wishes more the calories are increased to 2,200 or 2,500. Some patients can take much larger amounts of food than others without upsetting the digestion and in such cases a 3,000 or 3,500 calorie diet is given.

The diet used at the Presbyterian Hospital, San Juan, Porto Rico, has been worked out from Dr. Ashford's experiments on sprue. During the last few years a great many foods have been found to be satisfactory that were prohibited previously.

Type of Diet:

1. Reduction of carbohydrates: The use of cereals, starches and sugars is discouraged. Foods to be avoided are white flour in any form, canned soups, peas and corn, potatoes, rice, bread, crackers, canned fruits, pastries, jellies, cakes and sauces made with wheat flour.

2. Reduction of fats: Exclude all meat fats, butter, lard, pork and cream, except when the cream is taken in whole milk.

3. Increasing the protein intake: Milk, eggs and meat are an important part of the diet.

4. Supplying vitamin deficiency: Fresh fruits and vegetables should be included in the diet list to supply the vitamin and mineral deficiency caused by the improper assimilation of food.

Foods Allowed:

1. Soups, such as beef soup without fat, beef soup with sprue vegetables, chicken soup and milk soups without flour.

2. Meats: chicken, baked, broiled, stewed or creamed; lamb chops, lean beef, crisp bacon and dried beef.

3. Eggs, prepared in any way except fried.

4. Vegetables: white yautia, ripe platano, squash, chayote, tomato, celery, onions, cauliflower, carrots, eggplant, lettuce and asparagus.

5. Milk: to the amount of 1,200 to 1,500 c.c. daily.

6. Fruit: oranges, grapefruit, papaya, strawberries, mangoes and bananas. Sprue patients are often able to take from one to twelve bananas daily. They may be served cooked or uncooked and must be very ripe.

7. Desserts: custards, junket, baked apples, apple sauce, gelatine, grapefruit, oranges, bananas and fruit juice ices. All desserts should be prepared with saccharine.

The sprue patient must first be impressed with the importance of his diet for without his cooperation nothing can be done. If the disease has taken a severe hold on the patient, the diet must be continued for months, perhaps for years. If the patient is an American living in the tropics the only wise plan is to remain on the diet as long as he lives in the tropics. When the sprue patient rigidly adheres to a strict diet, remarkable and often permanent cures are effected. As a rule, however, in the more serious cases the diet must be con-



The investigations of Howland and Marriott show that the therapy of acidosis resulting from food intoxications agrees closely with the general effects of the treatment of acidosis in nephritis and in diabetes.

Food Intoxicants

"Phillips' Milk of Magnesia" is not only effective as an antacid but serves likewise as a valuable eliminant of toxic wastes. While the matter of diet regulation is of paramount importance, alkaline therapy provides a helpful adjunct. "The Dispensatory of the U. S." states that "in case of gastric hyperacidity, whether due to overacidity of the stomach or to fermentative changes in the foodstuff, it (Magnesia) is one of the best correctives that we have." The hospital can prescribe "Phillips' Milk of Magnesia" with confidence, because its patients, whether children or adults, find it palatable, easy to

take, and free from distension or gastric irritation. And beyond its pronounced antacid action it has the additional merit of being a laxative.

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tinued because any let-up often causes severe relapses and a loss of weight that may take months to regain.

Some of the results that were obtained at the Presbyterian Hospital in treating sprue are interesting, and are as follows:

Composite Chart of Eighteen Patients Treated With Sprue Diet. Average Stay in Hospital

Thirty-two Days			
	On Entrance	On Dismissal	Increase
Average Red Blood Cells	1,250,000	2,850,000	1,600,000
Average White Blood Cells	3,500	5,150	1,650
Hemoglobin	32%	53%	21%

These are just averages of eighteen cases but I should like to give histories of two exceptional cases that responded remarkably well to diet and treatment. They were treated by Dr. Galbreath and Dr. Burk at the Presbyterian Hospital.

The symptoms of sprue in the first case included loss of weight and strength; diarrhea of four months' duration; anorexia; sore tongue and flatulence.

About two years previously the patient had begun to lose weight and strength. He had about five or six bowel movements daily. His appetite had been poor for four or five months. His average weight two years ago had been 125 pounds, but had rapidly fallen to eighty-eight pounds. He grew progressively weaker each day, eating little at irregular intervals. He consulted a doctor and was told that he had severe anemia. He had also been feeling soreness along the edges of his tongue.

The treatment prescribed was a sprue diet, and calcium lactate grain 5 t.i.d., and pancreatin grain 5 after each feeding.

The patient made a steady improvement and developed a healthy appetite. The diet was gradually increased to 2,000 calories with eight ounces of milk every three hours. His hemoglobin increased from 40 per cent to 70 per cent in two months. The red blood cells increased 2,000,000 in two months and the weight increased from eighty-eight pounds to 113 pounds in two months.

The second case was diagnosed as sprue cachexia. The patient's symptoms had become evident sixteen months previously and he continued to grow progressively worse. He did not vomit, but food on reaching his stomach would ferment, producing gaseous distention. The patient was bedridden for several months.

Later the patient sought medical aid at our dispensary and with the aid of medicine the diarrhea was checked. His best weight of 130 pounds had fallen to eighty pounds. He was extremely emaciated and appeared chronically and seriously ill.

By degrees an extreme case of anorexia was overcome and the patient began to gain weight and in four months' time he had made a remarkable improvement.

	On Entrance	On Dismissal
Average Red Blood Cells.....	1,020,000	2,970,000
Hemoglobin	20%	80%
Weight	80 lbs.	120 lbs.

On leaving the hospital the patient promised to follow his diet as best he could provided he could secure money with which to buy the necessary food. Evidently he was successful because when he returned in a month to the dispensary he had gained six pounds.

These are but a few of the many cases treated at the Presbyterian Hospital. The list ranges from children to adults and includes many American adults. The cases come from all walks of life and all are treated equally.

New System of Baby Tagging Makes a Solomon Unnecessary

A system of baby identification in maternity hospitals that obviates any chance of mistake in claiming the right baby when the mother is ready to leave the hospital is described by Dr. Joseph B. De Lee, Chicago, in an article in the *Journal of the American Medical Association*.

This system includes first, complete information about the father and the mother, the nature of the birth, the name of nurse and the physician. When the baby is born the navel cord is tied with sterile tape bearing a numbered aluminum tag. Before the cord is cut the nurse ties the tape bearing the same number around the baby's wrist, and a third tape with the same number is fastened to the mother's wrist. These numbers are all set down in the time book, the navel wrist number being placed after the name of the child. The cord is then cut and the child placed in its crib. Adhesive plaster carrying the full information first taken is also placed on the infant's back. When the history is sent to the office the words "son" and "daughter" are used to prevent any error in transmission.

Two copies of footprints are made. When the child reaches the nursery its crib card is written out. This has the name, sex, date of birth, name of physician and navel wrist number. Before the umbilical stump has fallen off, which takes with it the numbered tag, the mother has learned to know her baby. If not, there are still the wrist number and the back plaster. In all cases the baby goes home wearing the wrist number and with the plaster still on its back.

Hospital Now a First Resort for the Sick Child

The hospital as a first, not a last, resort for the sick child is the remarkable evolution that has taken place in the hospitalization of children in the last sixteen years, according to data presented in a paper by Dr. Olin W. Rowe, Duluth, Minn., to the members of the Children's Hospital Association.

"During the early years there was a distinct prejudice against hospitalization of infants and children," Dr. Rowe said. "This was not confined to the parents but was shared to some extent by the physicians. It was a natural outgrowth of observations on the mortality rate of infants in maternity wards and to a lesser extent in the surgical wards. The occasional epidemic of communicable diseases which was not uncommon in hospitals at that time was also a factor. To conquer this prejudice was a long and tedious process."

Thorough examinations of newborn babies and all children in the hospitals served to reduce the risk of disease and abolished a certain amount of opposition to the children's hospitalization program. Pediatricians were engaged by the hospitals so that a more thorough service might be given to sick children, and comparisons of the various types of cases were recorded. With the aid of these records a study was made of the different methods of feeding babies and the methods producing the best results were adopted.

Despite a few who still retain pessimistic views, the hospitals are coming more and more to be used as health centers, a practice encouraged by and encouraging to the practicing physician, is Dr. Rowe's conclusion.

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OUT-PATIENT SERVICE

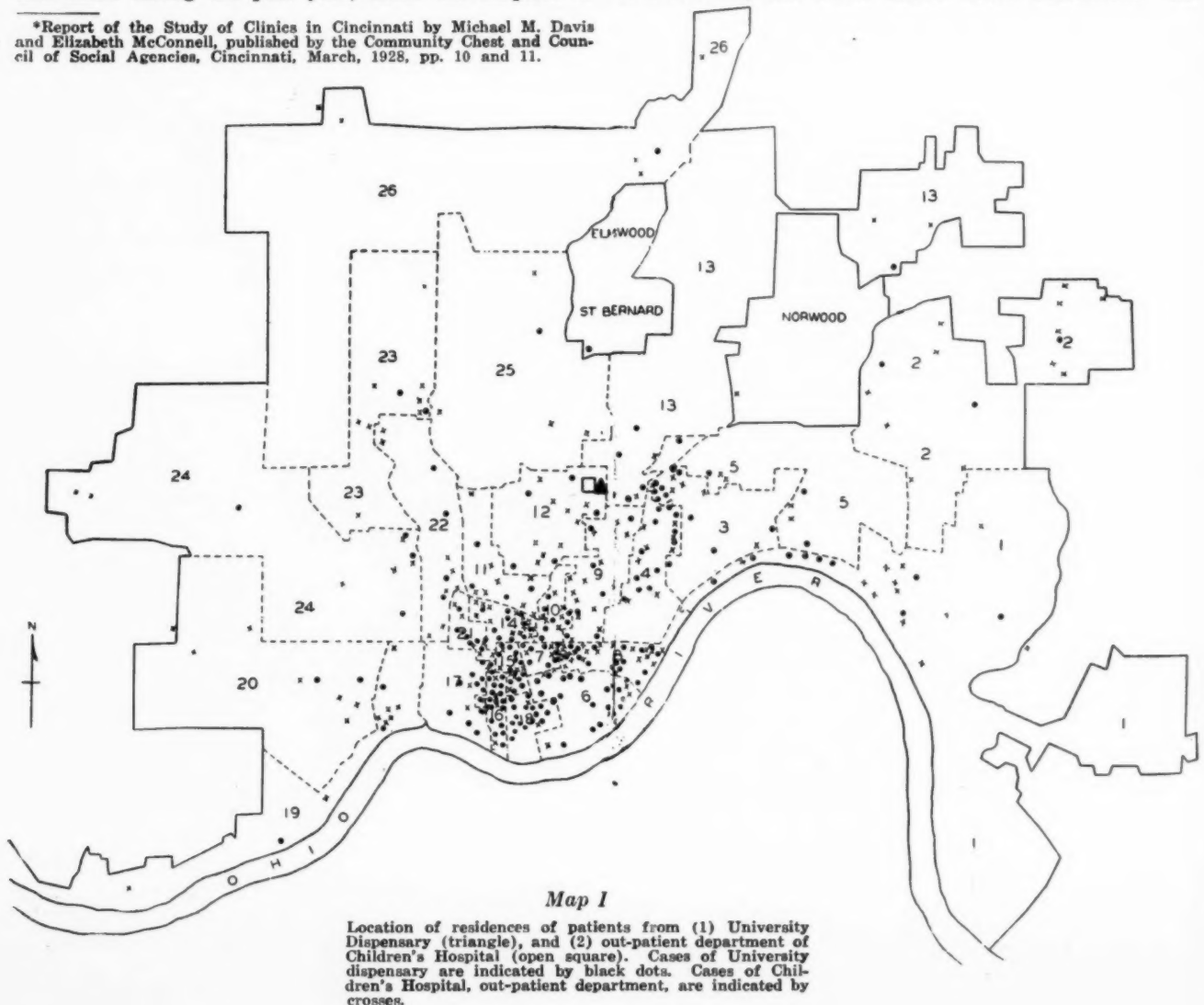
Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 151 Fifth Avenue, New York
A. K. HAYWOOD M.D., Superintendent, Montreal General Hospital, Montreal, Que

How Location Affects Clinic Patronage*

HOW far from home will a patient go in order to obtain clinic service? Can a clinic expect a satisfactory clientele if it is situated out of the central section of the city? To reach what type of clinic will a patient travel farthest? Questions such as these were carefully considered in the study of the clinics in Cincinnati made during the past year, under the auspices of

the American Public Health Association. The residences of the patients were spotted on the two maps illustrated. Map I gives the residences of patients attending clinics at the university dispensary and the out-patient department of the Children's Hospital; Map II shows the location of patients seeking service at two health centers and a clinic conducted by the Union Bethel Social Settlement. The

*Report of the Study of Clinics in Cincinnati by Michael M. Davis and Elizabeth McConnell, published by the Community Chest and Council of Social Agencies, Cincinnati, March, 1928, pp. 10 and 11.



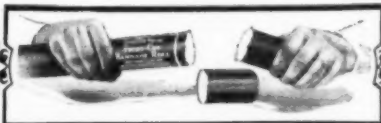


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report of the survey comments thus on the facts revealed:

"The spot maps may be studied both from the standpoint of the clinics that serve the people and from the standpoint of the people who are, or who need to be, served. From the standpoint of the clinics, the spot maps illustrate principles that may be stated somewhat as follows:

"What may be called a major clinic, one offering, as a teaching clinic particularly does, skilled diagnosis and treatment in many branches, draws from a wide area.

"Small clinics, offering less extensive and elaborate service, even if they do not deliberately district their work, draw in large part from a limited surrounding area.

"The preventive and educational work of a clinic, such as infant welfare or prenatal service, draws from a smaller area than does curative work, for the obvious reason that persons sick and anxious about their own or their children's condition will go considerable distances to a place where they think they will receive care, while for preventive or for educational work they will go only a comparatively short distance.

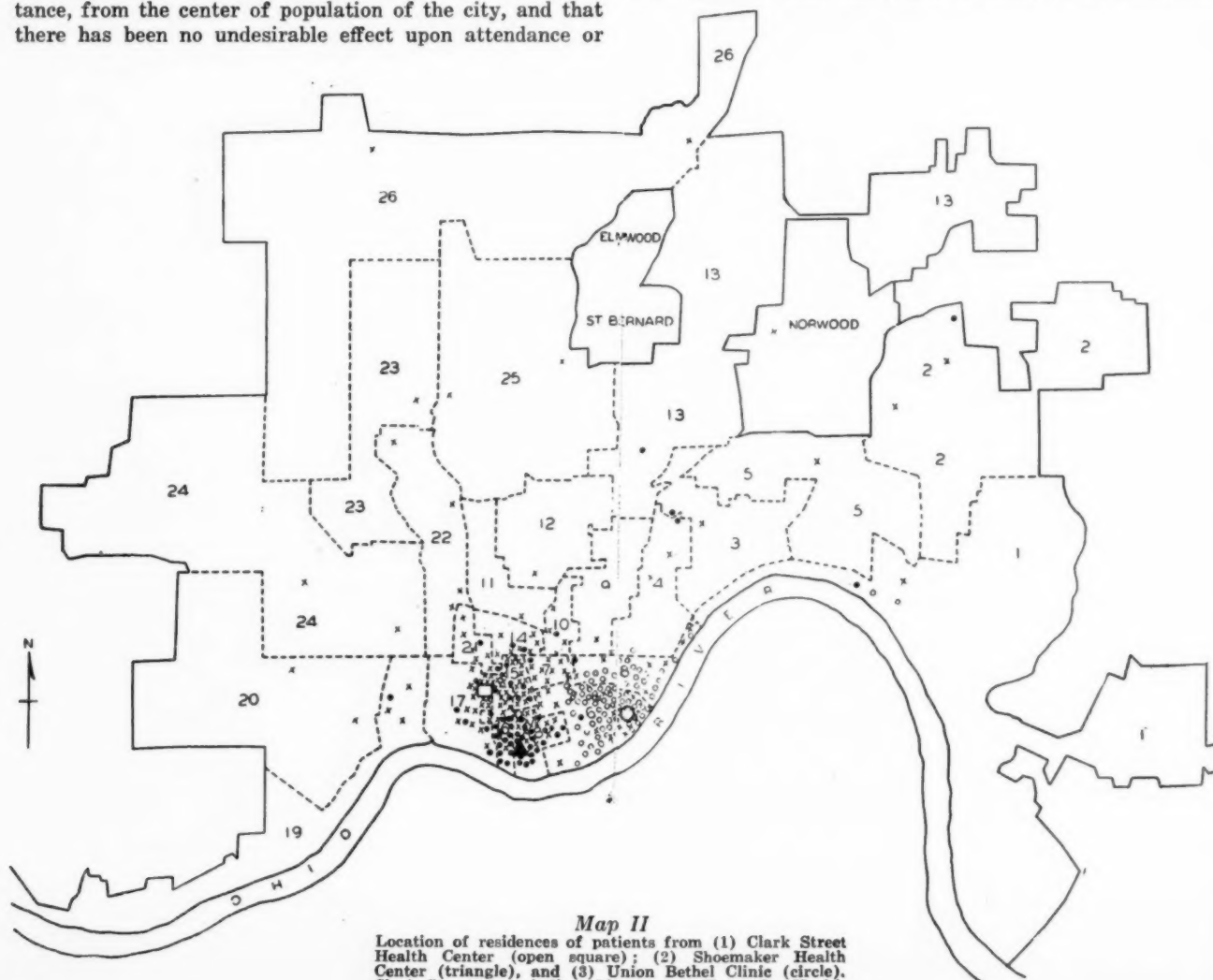
"In the past ten years there has been extensive experience in the development, location or relocation of out-patient departments and hospitals, both municipal and private, and particularly those associated with medical schools. In Buffalo, New York, Chicago, San Francisco, Rochester, St. Louis, and elsewhere, the experience has been that the out-patient departments, with the hospitals, have been located at a distance, often a considerable distance, from the center of population of the city, and that there has been no undesirable effect upon attendance or

upon the apparent usefulness of the service to those requiring it. In some instances, as in Buffalo and Boston, branch clinics have been located in downtown or outlying sections. There is ample experience to show that a major clinic draws from a wide area, and thus should not be located in a congested section because of transportation disadvantages to patients coming from a distance. Moreover, locating an institution in a congested section involves greater cost and fewer sanitary advantages.

"It will be seen on Map I that some patients come to the clinics at the General, Children's and Good Samaritan Hospitals from the downtown area close by. This is to be expected for these three clinics should be reference and treatment centers for the kinds of service that cannot be provided at the smaller district centers.

"From the spot maps and other facts it is believed that at the present time, at least, there are accessible clinic facilities for the downtown section, and that without establishing any additional plants there is easy opportunity for the development of any needed services downtown by extending the work of one of the four downtown clinics to include additional special branches as may be required.

"The facts lead to the conclusion that it is medically advantageous for the out-patient dispensary at the General Hospital to be adjacent to the hospital, on the same site, and that it is advantageous for the city as a whole to have the out-patient dispensary located on that site. The experience and actual practice of numerous other cities indicate that this policy is likely to be successful.



Map II
Location of residences of patients from (1) Clark Street Health Center (open square); (2) Shoemaker Health Center (triangle), and (3) Union Bethel Clinic (circle). Clark Street cases indicated by crosses; Shoemaker Health Center cases by black dots, and Union Bethel cases, by circles.

An Experiment in Education

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Massachusetts Is Aiding in Control of Cancer Through Clinics*

WITHIN the three past years the Massachusetts State Department of Health has organized cancer clinics in six communities and within a few months this number will be at least doubled. The first clinic was organized in December, 1926, and the sixth in June, 1927. This was the result of a law passed in Massachusetts in 1926, which laid the first responsibility for a cancer control program upon the health department.

"With over 5,000 deaths annually from cancer in Massachusetts," says Dr. George H. Bigelow, commissioner of public health in Massachusetts, in a recent report on the care and treatment of persons suffering from cancer, "and with the cancer death rate steadily on the increase, it seems absurd to await complacently the discovery of some medical cure for cancer before undertaking measures for the control of the disease. Such an interval of waiting in tuberculosis would have been inexcusable. For the state merely to supply a hospital or home in which the individual with cancer can pass his last days in some degree of comfort is equally shortsighted. A state cancer program must be broader and must include measures that attempt to reduce the number of hopeless cancer cases.

Cure Possible Through Early Treatment

"With our present knowledge," he continues, "the cure of cancer is possible only when diagnosis is made at an early stage of the disease and prompt treatment instituted. Any program that will successfully lower the cancer death rate must attack the delay on the part of the practicing physician as well as on the part of the patient. The most rational method of attacking these obstacles is by means of the cancer clinic.

"The clinic will first give an opportunity for individuals to receive diagnostic service. It will be composed of a group of physicians recognized in their community, who are all thinking in terms of cancer. Any individual regardless of his financial standing may receive an opinion from this group. Those able to pay will be referred from the clinic to private physicians, while those unable to pay will be referred elsewhere and followed up for care and treatment.

"That expert advice on cancer is needed for early diagnosis can be readily appreciated when it is realized that the average physician in Massachusetts sees four or five cases a year, and these of different types. As each type demands a different kind of skill in its diagnosis, a physician seeing fewer than one case a year of a given type cannot be expert. The staff of the clinic will be composed of a group, each seeing many cases of the type of cancer peculiar to his own specialty. The interest in cancer among the profession will be further increased by consultation visits, supplemented by forum discussions by experts from the larger centers. Group specialization in cases such as fractures and goiter therapy has accomplished much in improved quality of service.

"The surgeon will find patients more readily accepting his advice when it is supplemented by that of the clinic

group. Where clinics have been functioning it has been found that many persons who refused to take the surgeon's advice regarding early operation, after attending clinics and having the same advice given them, returned to their surgeon for treatment. The community spirit aroused by the clinics will have a tendency to keep the subject of cancer before the lay public, and can react only favorably in getting patients under treatment at a much earlier stage than is the case at present.

"The department is endeavoring to establish clinics in a number of strategic centers. Since a cancer clinic demands not a single physician, but a group of specialists, including the surgeon, the general medical man, the pathologist, the roentgenologist, the rhinologist, the urologist and the gynecologist, and since its needs are not limited to the four walls of the clinic room but demand the full resources of a modern hospital, the department has decided to stimulate clinics first in those communities that have the most to offer in professional cooperation and hospital resources.

"An opportunity is asked to present the program to the organized medical profession of a given city. If it seems suitable, the local medical profession passes a vote of support to the program and authorizes the appointment of a local medical cancer committee. This committee is responsible for determining where the clinic or clinics shall be held, for outlining the policies, organizing the staff, supervising the quality of service and directing the growth. The department meets with this committee to determine how it can best assist with its resources in personnel, supplies and funds.

Lay Committee Educates the Public

"The medical committee also appoints a local lay cancer committee. This committee must determine such matters as education of the local public in regard to available resources and to their proper utilization. It must face the unutterably tragic, social and economic problems that will be uncovered, and must decide the best solution of home or hospital care for the incurable, since many will not want to die in a remote institution. The department has personnel and other resources for these lay committees, but each community must be sufficiently stirred to the need of largely meeting its own problems. Too many sound programs have failed because of local indifference or antagonism.

"Each clinic is required to furnish a social worker. She will be appointed by and under the direction of the local committee. She will attend all clinics, will be responsible for all special records and reports and will do the follow-up work, visiting patients in their homes to see that they are receiving proper treatment and care. She will coordinate the clinic with other community social and welfare agencies both local and state. In many cases, she will diagnose the social and financial status of the patients and plan for their further treatment or hospital care.

"The minimum standard training for such a worker is graduation from a recognized school of social work, including a course in medical social service, or graduation from a recognized training school for nurses, plus a course

*Condensed from preliminary and final reports of the department of public health relative to the care and treatment of persons suffering from cancer. Massachusetts Committee on Public Health, December 15, 1926, Wright and Potter Printing Company, Boston, 1927.



The REVOLT of ROLLO MEEKER

RECORDS show that Rollo Meeker last lost his temper in the month of May, 1897. (He was married in June, 1897.)

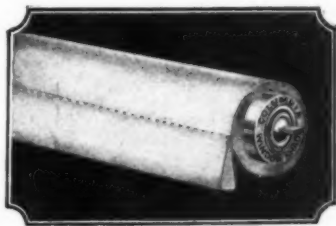
But look at him now. Roaring! Raging! Ramping! Rampaging!

For five years, he's been politely urging his wife to do something about those window shades. To get rollers that would really roll. This morning—as usual—it took him fifteen minutes to get the window shades in the living room adjusted. And,

suddenly, he just naturally boiled over.

en en

Don't wait until everybody's patience is exhausted with those old shade rollers (the jumpy, squawky kind) in your hospital. Any first-class department, house-furnishing or window shade store will estimate on the new *Columbia* Rollers—the kind with 30% to 40% reserve power — nickel plated ends—RUST-PROOF—self-lubricating bearings that are QUIET.



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Columbia **GUARANTEED** WINDOW SHADES
and ROLLERS

in public health nursing, or two years of general case work with a recognized social agency and a year's experience in medical social work.

"The department has a medical social worker whose duty will be to coordinate the social work in the various clinics and to find means by which follow-up work may be carried on in the nonclinic communities. The policies of social service as it relates to cancer control will be further worked out by the department with the aid of our advisory committee composed of leaders in the social and nursing field. Publicity will also be needed to disseminate facts regarding the possibilities of prevention and cure of cancer in its early stages.

"In some localities the clinic is a single hospital, while in others the clinic has branches in several hospitals and meets at different times in each of them. While the staffs of the different branches vary, there is but one management and one social worker.

"Up to January 1, 1928, 1,360 individuals have attended the clinics. In the records are many facts that may be instrumental in determining our future policies. Thirty-one per cent of the clinic attendance had been men and 69 per cent women, and 23.1 per cent were found to have cancer. Of the group having cancer 68.8 per cent were reported to be in the operable stage. The median age of the noncancerous individuals who attended the clinics was forty-six years, while that of the cancer patient was sixty years. Of those coming to the clinics 61.6 per cent came because of newspaper publicity, 20.1 per cent on the advice of a physician, and 18.3 per cent for other reasons.

"Of the individuals with cancer 14 per cent had never consulted a physician; 43.3 per cent had consulted one physician before coming to the clinic; while 33.1 per cent had consulted more than one physician, and the remainder gave no information."

How Shall the Nurse Training Problem Be Controlled?

Edwin R. Embree, president, Julius Rosenwald Fund, Chicago, and formerly director of the division of studies of the Rockefeller Foundation, in a recent issue of *Survey* writes of the problems of nursing education raised by the first published progress report of the Committee on the Grading of Nursing Schools.

He points out three great steps that have been taken for the advancement of nursing education since the world war: (1) the work of the committee of which Professor C.-E. A. Winslow was chairman and Josephine Goldmark, director, which issued the first formal systematic presentation of facts bearing on the nursing profession; (2) the establishment at Yale University of an experiment in nursing education; and, (3) the five-year study of the Committee on the Grading of Nursing Schools directed by Dr. May Ayres Burgess, which has just issued its first report of progress.

Contrary to popular belief it was found that there is no shortage of nurses, and still further, there may even be an overproduction, at least, an overproduction of nurses who have been trained in those hospitals that answer only the minimum qualifications of a nurse training school. In comparing the number of medical school graduates with the number of nurses as far back as the beginning of the century it was found that while the number of medical graduates has decreased about 25 per cent the number of graduate nurses has increased 500 per cent since 1900. Similarly the number of medical training

schools has diminished from 160 in 1900 to 79 in 1926, while the number of nurse training schools has increased from 432 in 1900 to 2155 in 1926.

The difficulty lies, not in obtaining nurses for any specific field of nursing, but in obtaining nurses who are satisfactory nurses for all cases. This apparently is the result of training given by hospitals which are not equipped with facilities for giving their students a broad education in the various fields of nursing, and who maintain the training school for the main purpose of obtaining cheap nursing labor for their wards.

"The inevitable conclusion from reading the report of this committee," said Mr. Embree, "is that it is high time to set about restricting the number of schools and the output of nurses and to put renewed emphasis upon proper standards and training in this profession."

Mr. Embree's brief review of the report, which is entitled "Nurses, Patients and Pocketbooks," failed to mention as one of the great problems of training schools the lack of education of a majority of applicants for entrance to the schools.

Why the Hospital Should Be Supported

Why should the person who never uses the hospital help support it?

This question was effectively answered by Mary Elizabeth Lewis, superintendent, Englewood Hospital Association, Englewood, N. J., whose experiences in raising money to build a hospital were recounted to the members of the New Jersey Hospital Association in a paper on "The Medical Staff Organization From a Hospital Superintendent's Viewpoint."

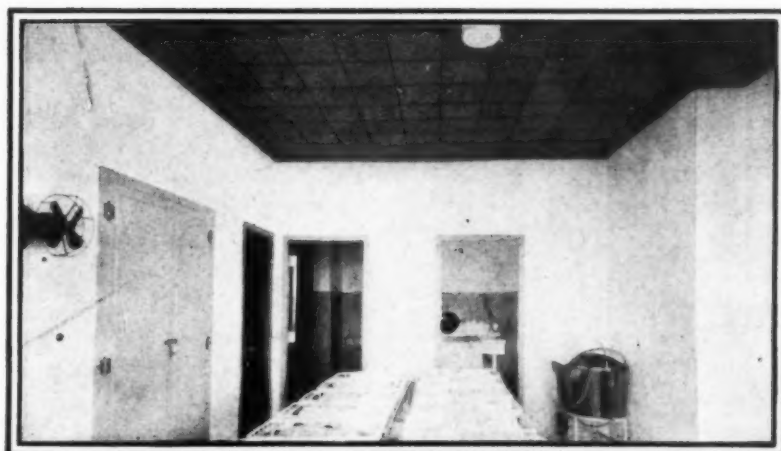
"Why should I give my money to build a hospital?" Miss Lewis was asked. And the questioner added, "I never use a hospital."

"The first reason that would come to anyone's mind," she replied, "is the selfish one of providing for you and yours when you need it. It is your health insurance. The hospital is a health insurance to the community and you should carry it just as you carry life insurance, to care for those who belong to you.

"Now, why do you expect a doctor to give service; not only expect it, but demand it? Is there any reason why a doctor should give his knowledge and his skill and his time, all of which are invested capital, to care for your need, if you are not willing to provide a place where that care and healing power may be applied?"

Some Advantages of Hospital Chutes

These are quite the regular thing in large hospitals but are seldom seen in smaller ones. The superintendent of a four-story hospital gave these as his reasons for having two chutes, one for laundry and the other for refuse: "Our corridors are no longer crowded by the waiting for freight elevators; we have more room for storage on each floor; the girls have more time to do other work now that they do not have to go to the basement with laundry and papers; there is less danger of fire; chutes are more sanitary than carts; chutes cost less in upkeep than carts, and in the long run are no more expensive than buying carts."



Infant ward, St. Johns Hospital, Tulsa, Oklahoma. Acousti-Celotex quiets the noises arising in this room, preventing them from reaching other parts of the building. Wight & Wight, architects; R. V. Aycock, Acousti-Celotex Contractor.

Quiets Noise in every room

MEDICAL authorities agree that quiet is a definite aid to speedy convalescence. It's much easier for patients to recover when their nerves are soothed with restful calm . . . unbroken by racket and confusion.

Yet many hospital rooms are far too noisy. Elevator lobbies in large city hospitals, kitchens and serving rooms are sources of irritating sounds which find their way all over the building.

You can easily protect your patients from this nerve-wearing noise. Acousti-Celotex applied in any hospital room, will reduce sound disturbances of *all* kinds.

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With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

Electric Refrigeration in the Darkroom

DR. ELEASAR R. BOWIE, assistant professor of roentgenology, Tulane University, New Orleans, La., presents the following interesting observations on electrical refrigeration in darkrooms in the current issue of the *X-Ray Bulletin and Clinical Photography*:

With the growing use of electrically operated refrigerating machines, it was felt that the darkroom of the modern roentgenological laboratory was a fertile field for their employment. Especially is this true in those parts of the country where weather conditions demand some reliable means of tank cooling during the greater part of the year, not only that the temperature of the solutions may be accurately controlled but that, additionally, the proper washing of the films may be accomplished without softening the emulsion.

Developing tank refrigeration calls primarily for reliable temperature control, the minimum of attention and the minimum of dependence upon outside agencies. Past experience with the use of ice had convinced us that proper standards of tank refrigeration had not been attained. Temperature control in the tanks, just as in the domestic refrigerator, varied decidedly with the ice supply and nothing short of an elaborate circulating system of iced water assured uniformity of temperature of the solutions. With ice there is the greatest difficulty in maintaining regularity of supply. The crushed ice in vogue in hospitals of late years necessitates the greatest care to avoid grease spots on the films as there is apparently frequent contamination of the ice with oil from the crushing machine.

Hospital-Made Ice Has Disadvantages

Few laboratories can expect to maintain storage facilities for ice beyond the actual requirements of the tanks and even in the hospital, the supply of ice is not dependable. This is an even more serious problem in the private laboratory since the ice man expects one delivery daily to suffice and that usually at an hour which suits his convenience but not necessarily yours. The cheapness of hospital manufactured ice is certainly largely offset by its disadvantages. Finally, in the well kept laboratory, the visit of the ice man is even more unwelcome than in one's home.

Electrical refrigeration meets ideally all the essential requirements and it is believed after an experience of more than one year therewith that it can be considered

capable of safely surmounting any temporary mechanical or electrical difficulty, owing to the large reserve of cold which is always at hand.

On opening a private office in September, 1925, the opportunity arose to use electrical refrigeration. From the beginning, the problem has been satisfactorily met. During this time the tap water has averaged about 80 degrees for at least six months each year and the room temperature has been proportionate.

The original installation was entirely experimental, the decision to use an electric refrigerating unit having been made only at the last minute after the usual soapstone tank had been ordered with the intention of using ice. Very little information seemed to be available as regards the use of electrical refrigeration and what little information was to be had, was quite discouraging as regards expense and reliability.

Water Cooled Machine Unsatisfactory

The first layout consisted of a water cooled machine of the type used in ice cream cabinets with cooling coils of block tin, circulating, by means of a pump, an alcohol brine. These coils were introduced into the wash compartment between the developer and hypo and also into the final washing compartment. As regards refrigeration, this arrangement proved satisfactory from the start but the consumption of electricity was rather excessive. The machine was in almost constant operation and the noise of the pump proved very annoying. Rather than make an effort to improve upon this arrangement, such as insulation against excessive loss of cold through the walls of the tank, it was decided to make a complete change in the plan and it is this present tank which is offered for consideration.

Provision was made for the use of five-gallon enameled solution tanks and a washing compartment of approximately twenty gallons accommodating twenty to twenty-five hangers. The main tank is of cypress, cork-board insulated and copper lined. In the middle of the tank are inserted the refrigerating coils. This master tank is filled with water. Into this tank are built two large metal tanks, the left-hand one containing the two enameled solution tanks surrounded by water with a wash compartment between, the right hand tank being the usual wash compartment. In the central space, between the solution tanks on the left and the wash compartment on

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Not only do we buy the finest quality of ingredients but we insist on the grade being always the same. Then, those ingredients are blended in an exact proportion under laboratory methods. A check-up is made, hourly, throughout the day to determine whether or not the proportions are varying from the fixed standard.

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Chicago, Illinois

the right, is provided a shallow catch-basin with drainage pipe. The solution tanks, as well as the wash compartment, are conveniently emptied by means of a water pump attached to the faucet above. Provision might easily be made at the bottom of the main tank for drainage of the water.

The next problem arose in reducing refrigeration to an extent sufficient to keep the solutions at 62-65 degrees and no lower. The electric refrigerator thermostat could not be relied upon for this as it is actuated, not by the temperature of the solutions but, by the temperature of the refrigerating medium. This might have been handled by a special thermostat dipping into the developer but it was found, by restricting the operation of the electric refrigerator to a certain number of hours per day, that the desired solution temperature was reached. In order that this might take place during the night, following a change of the water in the wash compartment and around the solution tanks (change of water in the master tank is of course unnecessary, replacement only of evaporation being required), a clock was installed to start the operation of the machine at midnight and stop it after 5-6 hours operation. (Similarly a clock was found useful in cutting off our film dryer an hour after leaving the laboratory.)

With this equipment we find our darkroom clean and dry and quite ideal and would not give it up for several times its cost. One of the best features is that it is actually paying for itself in the saving over the cost of ice. The electric consumption is approximately 50 KWH per month.

An additional installation was made very similar to the one described with the exception that composition five-gallon tanks have been used for the solution. The main tank is of oak with 3-inch cork-board insulation, lined with 1/4-inch lead. A third tank has been added to the two solution tanks to serve in prewashing between the developer and hypo. It is felt that this avoids to a considerable measure the rapid pollution of the main body of wash water in which the cooling unit is directly connected.

The company making the refrigerator now finds it possible with ordinary thermostat to maintain a temperature of approximately 64 to 65 degrees. Careful tests were made on both our tanks with a recording thermometer for a period of forty-eight hours during the use of the tanks. The curve was almost a straight line, never exceeding 65 and going no lower than 64. The current consumption remains at a minimum.

New Features Noted in Electric Tumbler Switch

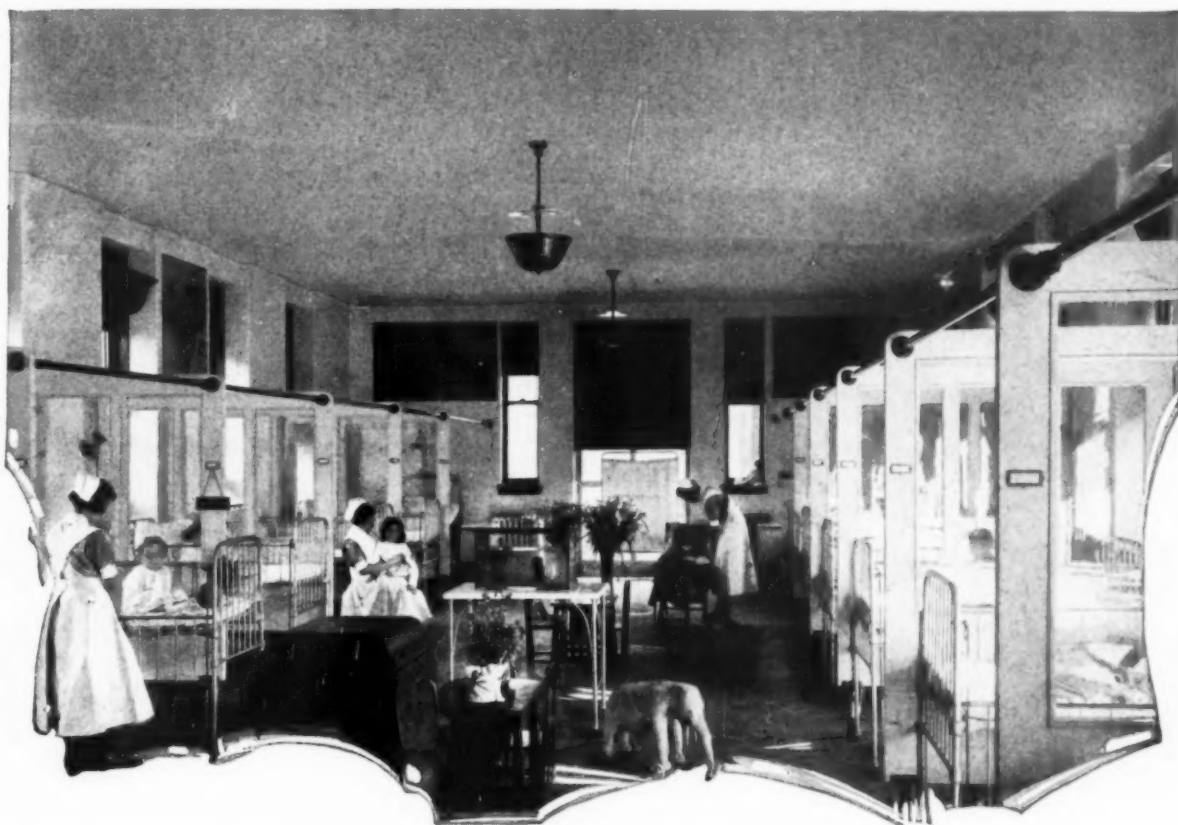
A new flush tumbler switch has recently been placed on the market. Its outstanding features are that it has "on and off" indicators on the brown composition handle, the latter being wider and heavier than on the ordinary switch. The porcelain cups are shallower, due to the improved design of switch mechanism which has few parts strongly made and assembled.

The mechanism and yoke are integral and these switches have a positive kick-off feature so that they cannot "hang up" in operating. The dust covers are stationary.

There is ample wiring room and each wire terminal is held by two screws. The binding screws are full sized and staked so that they cannot fall out. The contact blades are of phosphor bronze.

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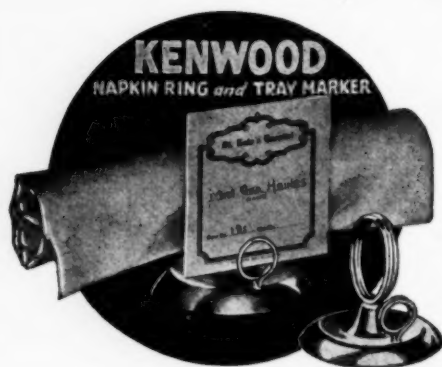
The congestion of traffic even in small cities, the type of construction now used, have served to add to the burden of noise which oppressed the sick and harried their attendants. Johns-Manville was the pioneer in developing materials to control sound. So successful has been the practical working of our methods that no hospital is considered complete today unless corri-

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- Additional thousands 2.25
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New Suction Apparatus Proves Satisfactory

By CHARLES E. REMY, M.D.

Superintendent, Michael Reese Dispensary, Chicago

We have recently developed at the Michael Reese Hospital, Chicago, what it has pleased us to designate as a foolproof suction apparatus. On the assumption that other hospitals have been meeting difficulties similar to those encountered by us, we bring the new apparatus to their attention. We have employed several types of machines and it has been our experience that practically all types are equally serviceable. Any one of the several types will give excellent service if supervised and taken care of solely by one person thoroughly trained and conversant with the mechanism.

Unfortunately, in a large hospital it is practically impossible to have the same person at all times available. When the operating room is functioning under full pressure, any one of several nurses may have to connect up the suction machine. The anesthetist may be requested

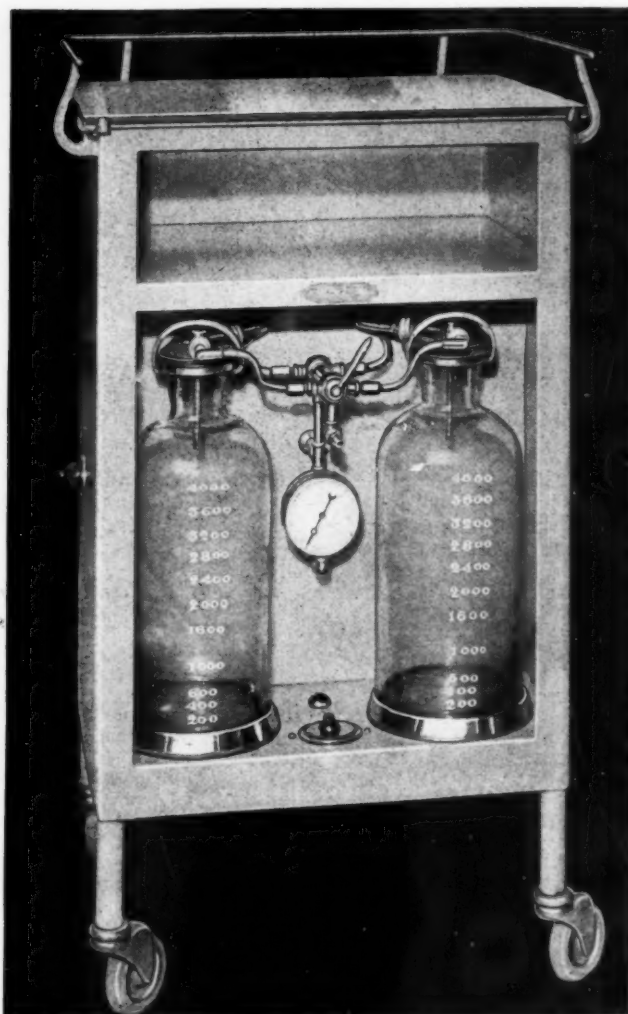
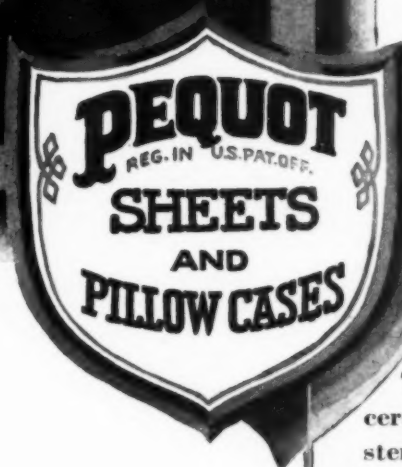


Fig. 1, showing front view of suction apparatus.

to supervise its operation. An orderly may be called to empty a bottle filled with blood or fluid. The inevitable result is a call sooner or later from an exasperated operating room supervisor to the superintendent or his assistant to the effect that "the suction machine is out of order again and is draining the blood directly into the motor

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instead of into the bottle." An even more exasperated superintendent then pays a bill of from five to twenty dollars for cleaning and repairing of the motor. Sometimes an attempt is made to fit the wrong cork in the wrong bottle and a vacuum cannot be obtained. On another occasion the surgeon comes to the superintendent's office to complain bitterly of the fact that he never performs a

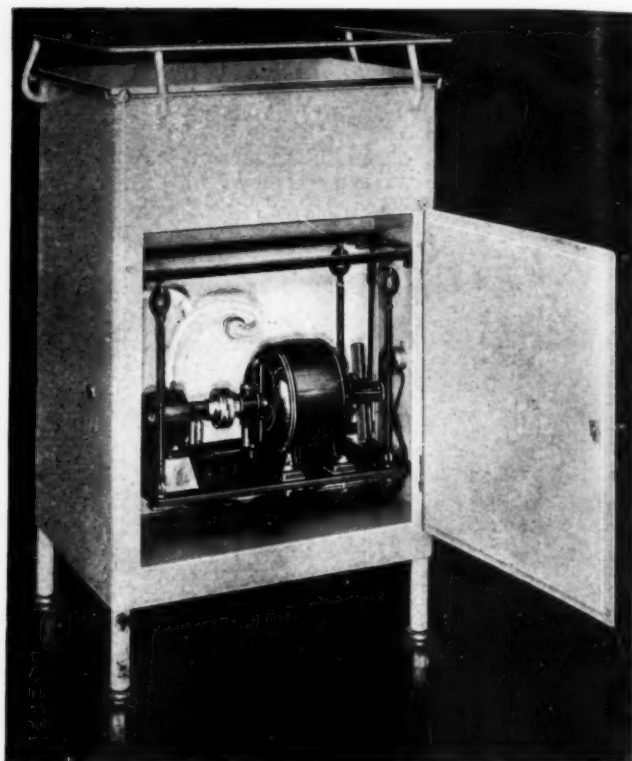


Fig. 2, rear view, showing separate compartment for motor.

major operation that he is not interrupted at the most critical stage to permit someone to change a bottle in the suction machine, while he has to resort to sponging or wait while the nurse or orderly completes their operation upon the suction machine.

The suction machine that we are now using was evolved as a result of our grief with other types of machines. It has been in daily use in our operating rooms for more than a year and has served to eliminate fully all irritating incidents such as above described. The accompanying illustrations (Figs. 1 and 2) give front and rear views of the apparatus, showing strength of construction and general appearance. Attention is directed to the large recessed bottles, graduated and of extra heavy glass, and likewise to the shelf space above and to the broad top, the two latter rendering the apparatus serviceable as an anesthetist's table, if such is desired, thus eliminating one additional piece of furniture from crowded operating rooms.

Fig. 2 shows the enclosed, one-sixth horse power motor, controlling the vacuum, which is swung from above to eliminate both vibration and noise. It will be noted that the motor is of the screened type. Manufacturers maintain that this screening is in itself full protection against any dangers from spark, but in this apparatus we have added the additional safeguard of the steel door, thus entirely enclosing the whole motor in a separate compartment. In Fig. 3 note the shelf for notebooks, paper and pencils (A), and point for attachment of rubber suc-

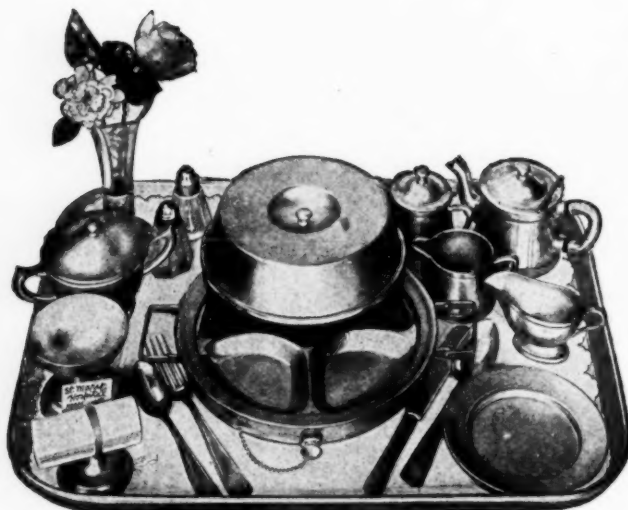
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NEW YORK CITY

tion tubing to lead to surgical field of operation (C). Particular attention is called to the reversible stop-cock lever (B), which serves to divert the incoming fluid from one bottle to the other without interruption of vacuum and without annoyance to the operating surgeon. The full bottle may be removed, emptied, and replaced, likewise without interruption of vacuum and without disturbance to the surgeon. Emphasis is laid upon the fact that the top

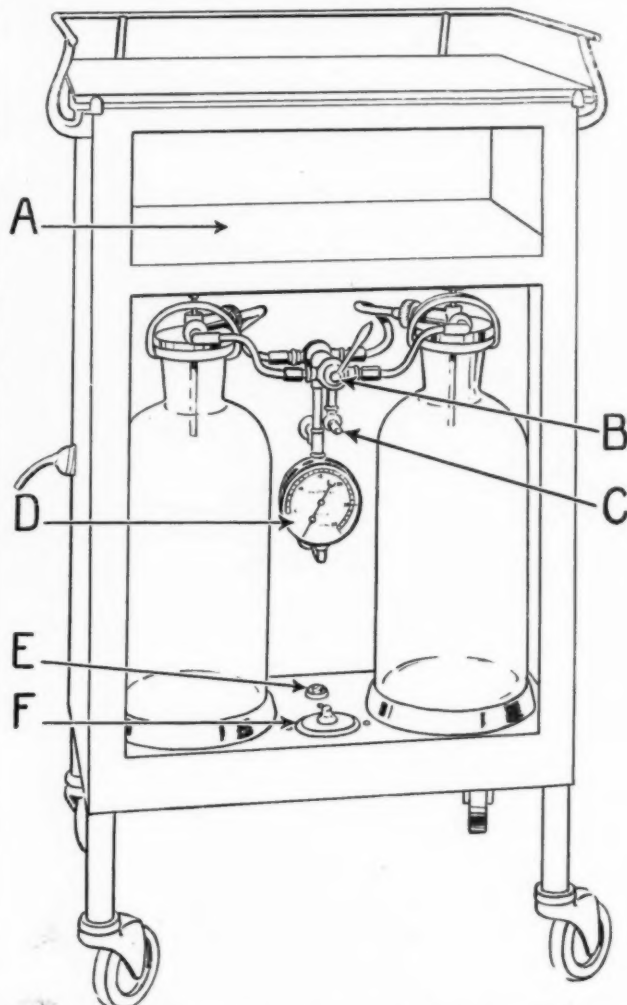


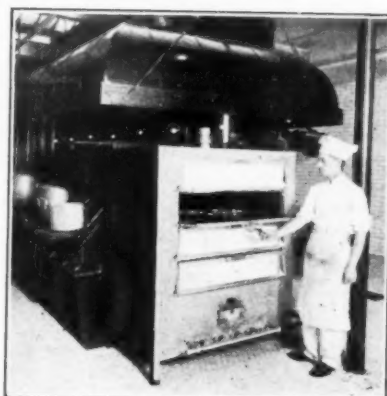
Fig. 3. A. Shelf for notebooks. B. Valve and handle for directing flow of aspirated fluids. C. Connection tip, for attachment of suction tubing. D. Vacuum gauge. E. Pilot light. F. Motor switch, spark protected panel toggle switch.

of the bottle can be reattached in but one position, and errors in the technique of replacement are thus completely eliminated so that fluid cannot be sucked into the pump.

Operating Central Tray Service

One of the features at the Catholic Hospital Association convention held at Cincinnati in June, was the demonstration of the central kitchen and tray service at the Jewish Hospital of that city.

Fully one hundred delegates interested in dietetics availed themselves of the opportunity to see the method that originated in that hospital. Louis Cooper Levy, superintendent of the institution, explained the working



This Thrift Gas Oven is used in the Roosevelt Hospital, New York City, for practically all baked foods served.

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For Invalid or Convalescent —Better Baked Foods!

Not only better baked—but much more economically baked, if the Thrift Oven is used.

The Most Economical Portable Bake Oven on the Market

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An authoritative review of the latest findings in nutrition

FREE to dietitians and nurses

"Here is the gist of all that is latest and best in the field of nutrition, printed in convenient, practical form," says a dietitian in one of Chicago's great hospitals.

This new booklet, "A Brief Summary of the Principles of Nutrition," has been prepared by an authority on health and nutrition. He is also an eminent active practitioner, on the staff of a leading hospital.¹

In brief, concentrated form it summarizes the very latest facts concerning nutrition. There is a chapter called "The keynote to a practical understanding of nutrition"; others on "The classes of food stuffs," and "The balanced diet."

The booklet is distributed by the Cream of Wheat Company, makers of that cereal which has been recommended by leading doctors for thirty-two years. Send for your copy today. It is free.

¹As this is an advertisement, it is not possible to name the scientist who has prepared this book. His name will be furnished upon request.

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Nursery NAME NECKLACE in HAWAII



Just as passengers on ships arriving at this Mid-Pacific isle are greeted with the quaint native custom, wherein a lei or wreath of welcome is placed around their necks—so it happens that in Queen's Hospital and Tripler General Hospital at Honolulu arriving travelers to this earthly sphere—new born babies—are greeted with a blue bead necklace wreath of welcome and sane identification, placed and sealed around their necks—the Nursery Name Neck-lace.

The fame of this "Positive Identification of the New Born" is traveling far—and it is universally liked on all continents. Easily understood by all peoples, free from all complications—building confidence and good will—stamping the reputation of maternity onto the hospitals' obstetrical procedure—it is the most extensively used of all baby identifications.

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of the system, emphasizing the necessity of having the proper equipment, namely, a food conveyor, hot plates and vacuum pots for tea, coffee and soup.

The delegates were escorted to the model kitchen and watched the dietitians and assistants deliver seventy-five private room trays in sixteen minutes.

The conveyors, holding twelve trays, size 22½ by 16½ inches, were followed to the various floors, where they were delivered. Three important facts were noted: (a) no odors of cooking were noticeable in the hospital; (b) the pupil nurses did not carry the trays to or from the patients' rooms; (c) the trays were collected by the same two persons who delivered them.

The Sisters were impressed with the method in vogue and asked many questions. Superintendent Levy explained the handling of patients' orders, stating that the head nurse calls each morning to obtain the orders of food for the following day. These orders are made in triplicate, one copy remaining in the chart room for future reference and two copies being collected each day at one o'clock, by a dietitian. One copy is kept intact to take off quantities and for reference and one is cut in squares. These squares are placed on each tray, which is set up after each meal.

Explaining further Mr. Levy said:

"The tray wagons are wheeled into the kitchen, facing the cold service. Here the maids place on them the salads, bread, desserts, butter, and coffee or tea in vacuum pots, in advance of the 'zero' hour, which would be 7:45 a. m. for breakfast, 11:30 a. m. for dinner and 4:45 p. m. for supper.

"At the 'zero hour' the large tray carts are swung around, facing the private patients' range, as directed by the dietitian, who consults the order form on each tray. The hot food is placed on patented hot plates. As quickly as the cart is loaded it is transported by a man and a uniformed woman attendant, to the specified floor. As the cart comes to a halt before each private room, the attendant pulls out the tray while the maid holds open the screen door and interior door, enters the room and sets the tray in front of the patient on a tray table. This is done quickly, and as soon as the twelve trays are delivered the cart is left in a side room, awaiting the collection of the used trays. The pair then return to the kitchen for another cart. The pupil nurses do not have to handle the trays.

"In the meantime, a second pair of attendants completes the same round on other floors. One hundred private trays can be served in thirty minutes from the time the hot food has been placed on each tray. This system prevents overcrowding diet kitchens on each floor and permits nurses to care for more patients. The system requires vacuum pots for soup, coffee and tea and also hot plates. The trays are collected after each meal by the same attendants, which insures the return of dishes and silver for sterilization in modern dishwashers.

Dishwasher for Diet Kitchen Requires Little Space

A dishwasher of convenient size for the small hospital kitchen or for use in the diet kitchens of larger institutions has recently proved popular. It requires little space, being twenty inches square, is finished in monel metal and can be installed in the ordinary diet kitchen with little trouble.

Three baskets are provided. One holds the plates,

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TRADEMARK
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MATTRESS

Comfort Supreme

"You can't buy
bed-comfort by
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This shows the
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Mattress on a hos-
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**Help the patient to sleep completely
relaxed**

In less than a year and a half more than 390 hospi-
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The following hospitals are among those using
large quantities of Spring-Air Mattresses:

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LAKESIDE HOSPITAL, Kendallville, Indiana
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ROBERT PACKER HOSPITAL, Sayre, Penna.
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ions roll and
fold as easily
as the pad—
True flexibility.

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"Spring-Air Mattresses are giving such wonderful satisfaction
that I am equipping our entire hospital with them as rapidly as
possible. Our patients as well as the doctors and nurses are per-
fectly delighted with these beds."

We wish to thank the many delegates who visited our booth in San Fran-
cisco and for the compliments that we have been hearing ever since the Con-
vention. Many have said that the Karr exhibit was the most interesting and
most worthwhile.

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A Sanitary, Non-tangling Tea Ball



The new non-tangling White Rose Tea Balls meet the most exacting requirements of the modern hospital.

A patented method of clipping the tag to the ball makes it impossible for balls to become tangled and snarled. Saves time and annoyance in preparing tea, and guards against waste of balls. When ball is to be used, a slight pull detaches tag.

White Rose Tea Balls are manufactured by modern machinery and are delivered to you untouched by human hands. The tin container seals in the full strength and flavor of the tea and protects it from foreign odors and all outside contamination.

Packed 100 Tea Balls to the tin, 6 tins to the case. Each ball will brew one to three cups, according to strength desired . . . Orange Pekoe and all other varieties.

Free samples gladly sent on request, or let us send you a trial order at the prices given below.

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Delivered Prices	East of Miss.	West of Miss.
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another holds glasses and small pieces of china and the other, which is of closely woven wire, holds the silverware. The rack on which the baskets rest is easily removed, as is the revolving spray, so that the inside of the washer can be cleaned with no trouble.

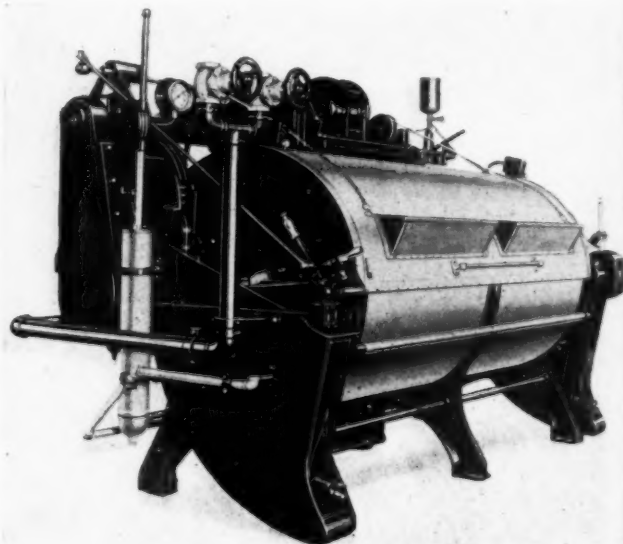
The hood and control handle are interlocked so that neither wash nor rinse can be turned on while the hood is up, nor can the hood be raised while the machine is in operation. When the hood is closed and the handle turned to the left the wash is on. In this position the machine can be left while the operator attends to other duties. The lever, when turned to the right, however, is on rinse and must be held in this position as a spring returns the handle to neutral when released.

The operating mechanism is underneath the washer, but provision is made so that it can be oiled from above. A steam wash can be provided if desired.

Unloading Washer and Extractor Reduces Labor in Laundry

A washer and extractor of the unloading type has proved to be effective in reducing labor in the hospital laundry. The cylinder of the washer is lifted out of the tub by means of a huge lifting gear. At the same time it is inverted and the work is dumped out through the opening into the extractor containers or into truck tubs. The washer is made in several sizes and is constructed of monel metal.

The extractor is made in one size only with a basket fifty-four inches in diameter, in which are placed, in a locking position, two containers that are flat on one side and semicylindrical in shape. The two containers are



brought together on the flat side and placed in the extractor basket by means of a hoist. The containers are constructed of aluminum alloy, with perforated sides and hinged bottoms, to allow the work to be dropped out of the containers after extracting. These containers are equipped with casters for easy movement on the floor or when at the washer being unloaded. The hoist, by means of which the extractor basket is conveyed from place to place, is suspended from a track that is built into the ceiling. The track can be supplied in any desired length at small additional cost.